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Exploring Community Attitudes to People with Learning Disabilities: Using a Micro-Neighbourhood Design

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Abstract

People with learning disabilities living in the community strive for meaningful social inclusion and integration. The attitudes of society to such individuals living in communities continues to be the catalyst that will enable them to achieve genuine social inclusion and integration. Identified barriers to social inclusion are a lack of change in societal attitudes towards people with learning disabilities. People with learning disabilities should live in a socially, not just functionally, integrated manner in community settings. Hence, attitudes of the community are extremely influential in achieving social integration and inclusion. It is important therefore to plan how best to capture attitudes in fact. An exemplar of a completed comparative study in Ireland, which used a micro-neighbourhood design combined with a random survey, illustrates how attitudes can be researched effectively. Study findings show that while attitudes were generally positive towards people with learning disabilities, there was no evidence of social integration, only functional integration. These findings reflect the challenges of achieving authentic social inclusion and integration and warrant further exploration by government agencies and service providers for people with learning disabilities. The study design outlined can contribute to gaining a true insight of societal attitudes.

Keywords: attitudes, community, learning disabilities, social inclusion, micro-neighbourhood

1. Introduction

Today, people with learning disabilities live in the community and strive for meaningful social inclusion [1]. The attitudes of society to such individuals living in communities continue to be the catalyst that will enable them to achieve genuine social inclusion

and integration [2]. Debenham [3] identified a barrier to social inclusion as the slow or complete lack of change in attitude from people in society towards people with learning disabilities. This paradigm of care, which focuses on community living and social integration, is however influenced by the attitudes of the general public [3]. In attitude research, expressed opinions may not be the views in fact held by respondents, but views in principle only [4]. Presence without participation can be more isolating than no presence at all [5]. Over the last number of years, there have been significant advances in the growth and development of services in the community for people with learning disabilities worldwide. Contemporary evidence-based practice has focused on the philosophy of social inclusion for people with learning disabilities living in the community [6, 7]. This philosophy is based on the proposition that the quality of life of a person with a disability increases as access to culturally typical activities and settings increases.

The chapter will firstly provide a brief discussion on the move from institutional to community care for people with learning disabilities. It then explores attitudes and the possible influences of these attitudes towards people with learning disabilities. This will then be followed by an exploration of researching attitudes. An exemplar of a completed study in Ireland, which utilized a randomized survey combined with a micro-neighbourhood design, will then be discussed.

2. Attitudes towards the care of people with learning disabilities

Over the years, perceptions towards disability have varied significantly from one community to another and traditional approaches to the care of people with learning disabilities have a rather tarnished history [6]. In this chapter, learning disability is categorized according to the international classification of diseases (ICD) [10] where it is classified as a condition of arrested or incomplete development of the mind, which is characterized by impairment of skills, and manifested during the developmental period, which contributes to the overall level of intelligence, i.e. cognitive, language, motor and social abilities [8].

When children who were labelled 'feeble minded' grew into adults, those who could no longer be taken care of in their own homes were put into asylums or workhouses [9]. Goffman [10] spoke of such institutional care as the tendency towards the absolute control of every aspect of a person's life and which led him to coin the term 'total institution'. This was a situation where people were totally cut off from the wider society for an appreciable period and all aspects of life were conducted in the same place in the immediate company of others and all within the same hierarchic and bureaucratic framework [10]. Similarly, King et al. [11] wrote on institutional care and described how it included block treatment, rigidity of routine, social distance and depersonalization. Goffman referred to living in such institutions as being stripped of one's identify kit [10].

For people with a learning disability, the situation was even worse because their experiences may only have been of institutional life and their '*identify kit*' may solely have consisted of

institutional life and practices. It is very evident that these institutions failed to provide normal experiences for those with a learning disability.

3. The move to community care

In many countries, the 1970s brought about major changes in where those with a learning disability were housed and cared for. Normalization as a philosophy of care originated in Scandinavia at the end of the 1950s as a reaction to the shortcomings of institutional care for those with a learning disability. It was based on the premise that the quality of life of a person increases as access to culturally typical activities and settings increased in the person's life. The principle of normalization rested on the premise that people with learning disabilities should enjoy, as far possible, the services available to ordinary people. This philosophy offered a powerful stimulus to the replacement of institutional care [12].

Bank-Mikkelsen [13] defined normalization in terms of enabling people with learning disabilities to live similar lives to people without disabilities. Wolfensberger [14] defined normalization as the utilization of means that are as culturally normative as possible with the avoidance of special segregated services. He later suggested [15] that the term normalization should be changed to social role valorization as he felt that this emphasized the true goal of normalization—that is the development of valued social roles for all people who are at risk of social devaluation.

4. Social inclusion

Over the past 30 years, people with learning disabilities have increasingly been living in community settings rather than in segregated facilities and this pattern is reflected internationally [16–17]. People living in the community are assumed to be more likely to use community resources and to have more opportunities to experience roles and relationships that are inherent to being part of a community, thus achieving social inclusion [18].

Social inclusion can be described as not only being present in a community, but also having meaningful social connections and participating in fulfilling social activities [19]. Clifford-Simplican et al. [2] further define social inclusion as the interaction between two major life domains: interpersonal relationships and community participation and developed an ecological model of social inclusion that includes individual, interpersonal, organizational, community and socio-political factors.

It is widely acknowledged that this community participation remains an important element of well-being for people with learning disabilities [18] and a key component of the United Nations Convention on the Rights of Persons with Disabilities [19]. People with learning disabilities, however, continue to experience high rates of social isolation [18, 20–24], and their social networks are composed mainly of family members and professionals [25]. The pattern

of service provision perceived by Ritchie [25] in 1999 was one of the segregation and could still be said to be the same.

The aim therefore of service providers who wish to improve the lives of people with learning disabilities should be to reduce segregation and promote social inclusion. It seems that people with learning disabilities living in community settings participate more than people living in segregated setting; however, the level of participation is still much lower than in other marginalized groups [17, 26–27]. For social inclusion to occur, consideration must be taken of the attitudes of those in communities towards people with learning disabilities.

5. Attitudes

Belief systems, values and attitudes impact on how a person responds to others, those with or without a learning disability, either at an individual, group or societal level [25]. McConkey [27] defines attitude as peoples' expressed opinion and their anticipated reactions towards specific events within their personal experience.

Attitudes can also be defined in terms of mood, thought processes, behavioural tendencies and evaluation [28, 29]. Evaluations including cognition, affect and behaviour are fundamental to the notion of attitudes. Cognitive evaluations refer to thoughts people have about the object. Affective evaluations refer to feelings or emotions people have and behavioural evaluations refer to people's ensuing actions. Attitudes are generally accepted as stable qualities in a person or society and empirical evidence would suggest that attitudes are cognitively and behaviourally learned rather than native [29].

In relation to learning disability, Gellman [30] proposed that positive or negative societal attitudes to people with learning disabilities are learned in early childhood and are dictated by socially accepted norms whereby society creates attitudes towards the people who are categorized as different.

Thomas [31] suggests that societal perceptions and treatments of persons with disabilities within all cultural settings vary from acceptance or tolerance to hatred or indeed awe or revulsion. The affective attitudes held by society as identified by Wright [32] included pity, fear, uneasiness, guilt, genuine, sympathy and respect. These attributes are clearly divided into positive and negative categories and are likely to impact the relationship between persons with disabilities and society. Negative attitudes can and do stigmatize people with disabilities, thereby, denying them equal opportunities for personal and professional development, living options and demoting them to second-class citizens, who should be pitied [33].

In many instances, the initial response when dealing with people with learning disabilities is to place the individual in a predetermined category based on what is assumed to be his or her attributes and status based on exterior appearance. Such attitudes produce stigma and isolation. Wright [32] describes the phenomenon of stigma extension as taking place when a person with a disability is viewed as disabled not only with respect to the specific area of disability but also to other characteristics.

Societal attitudes are significant since they largely determine the extent to which the personal, social, educational and psychological needs of people with learning disabilities will be met [34–35]. From every standpoint, whether that of human rights or social desirability, people with learning disabilities should be treated equally with all others. Those labelled ‘disabled’ are often treated differently by society, which may emphasize the disability of the individual instead of their ability. Ritchie [25] identified that adults with a learning disability are much less likely than other people in society to have their own home, to have a paid job, to be included in their local school, to have a network of social contacts or to have a bank account.

Bert Massie, Chairperson of the UK Disability Rights Commission, highlighted that attitudes to disability are the major barrier to peoples’ full participation, integration and acceptance by societies [35]. While such negative attitudes persist, the full rights of people with learning disabilities will not be justly realized [37]. Researchers no longer question if attitudes predict behaviours, but under what circumstances do attitudes predict behaviours [38]. Behaviour is related to attitudes in complex ways and many factors do influence the attitudes of society.

Attitudes are directly influenced by personal experience of events or people and resultant positive or negative reinforcement outcomes [39–40]. Attitudes are indirectly swayed by social learning and observation or by learning through association [39–40]. A clear relationship exists between attitudes and personal experience of disability and this truism has been identified in many research projects worldwide [41–43].

The role of direct experience may be particularly important in attitude formation. Positive effects of contact have been demonstrated in many arenas including attitudes towards the elderly, psychiatric patients and children with disability [44–47]. Attitudes formed through direct experience may be better predictors of later behaviour than attitudes formed through indirect experience.

Hewstone [46] attempted to answer how direct contact between groups work in changing attitudes and diminishing or banishing prejudices. Pettigrew and Tropp [45] proposed four major potential mechanisms: learning about the other group, the ‘*out group*’; behaviour-driven attitude change, e.g. forming more positive attitudes after cooperating in a learning task; ‘*in-group*’ reappraisal and; generating affective ties. It is engendering affective links, including the creation of close friendships that seems to be the most effective strategy in reducing negative stereotypes and misinformed preconceptions about disability.

Deal [47] found that the contact hypothesis was not supported by his research on attitudes of people with disabilities to other people with disabilities and diverse functional impairments. He suggests, however, that whether the contact between people with disabilities is voluntary or involuntary may be a significant variable. Allport [48] in his classic volume, *The Nature of Prejudice*, expounded the contact hypothesis for future generations of policy makers and social psychologists.

Hewstone [46] demonstrated through research that contact works to improve attitudes, how it works and when it works. Antonak [49] showed that the most influential factor in the attitudinal scores in his study was the intensity of contact with people with disabilities and centred on the impact of contact, however this contact must be on at least equal terms [49].

Wai et al. [40] found, in common with other studies including Gelber [41] and Elmaleh [42], that contact and knowledge factors influence the development of positive attitudes towards people with disabilities.

5.1. Researching attitudes

Experts in attitude research generally divide methods to measure attitudes into direct and indirect approaches [50]. Direct methods involve the respondents being aware that they are participating in attitude measurement and typically involves self-report surveys. Due consideration should be given to the use of more subtle or indirect methods of assessing attitudes. People may often hold subtle forms of prejudice towards disability that may not be detected when using more direct methods that allow respondents to respond in ways they consider more socially appropriate [51] and therefore while it is now more socially appropriate for the public to espouse positive global attitudes towards disability than negative, specific attitudes, if investigated, may be found to be more negative [4]. This social desirability phenomenon, where it becomes more appropriate socially to express certain sentiments and attitudes, may not necessarily be reflected in behaviour.

Ichheiser [4] was a social psychologist of the Austrian phenomenological tradition wrote in depth about attribution biases long before other theorists. He theorized that people have two aspects of personality, their visible outside that is exposed to pressure and control from others and an invisible inside. In other words, society misshapes the image of the other person by describing certain characteristics to their personality. He argued that attitudes and opinions are often based on the assumption people do have definite attitudes and opinions, however most people have confused ambiguous indefinite opinions and attitudes about many things, and their attitudes and sentiments are often still more confused [4].

Therefore, Ichheiser [4] maintained that the findings in attitude research seriously missed the point. The reason for this was that people expressed to use '*views in principle*' and '*views in fact*'. He suggested that views in principle are how people think they would act or how they think they should act when confronted by issues are events that are important. *Views in fact* determined a person's actions and reactions when exposed to certain events or issues. He posited that both views were genuine. This theory assists in explaining how members of society, for example, who live in areas where there were no community-homes express no reservations about having people with learning disabilities as neighbours [views in principle]; whereas views in fact surface when a community based home for people with learning disabilities is next door to their home. This latter attitude is referred to as not in my backyard (NIMBY) effect.

Ichheiser [4] theorized that to prevent distance confounding attitude results, immediate neighbours should be targeted in attitude research. Therefore, in researching attitudes, a micro-neighbourhood has utility and applicability.

Decisions on choice of instrumentation to measure attitude are always a compromise between the ideal and the practical. It is advisable, however, to use a previously developed validated instrument that has been used in similar attitude [27] research, as showcased in the exemplar, Methodology section. Other widely used instruments to examine attitudes towards people with learning disabilities include the *Attitudes towards Disabled Persons Scale* [ATDP, 52] and the *Scale of Attitudes towards Disabled Persons* [SADP, 53]. Both these tools assess attitudes from a

social as opposed to a personal perspective with questions centring how persons are, or should be, treated at the societal level [54]. The latter instrument however poses concerns, specifically relating to socially desirable responses (views in principle) and false positive scores. A more contemporary instrument, commonly used, is the *Attitudes towards Intellectual Disability Questionnaire* [ATTID, 55]. This instrument was developed according to a multi-dimensional model [56] addressing affective, cognitive and behavioural components of attitudes. The ATTID is based on several previously validated instruments such as the *Mental Retardation Attitude Inventory—Revised* [57], the *Behavioural Intention Scale* [58], the *Community Living Attitudes Scale-Mental Retardation* [59], the *Pictographic Scale* [36] and the interview questionnaire from the *Multinational Attitude Study Survey* [60]. Cronbach's alpha coefficients for the ATTID range from 0.59 to 0.89 showing good internal consistency for the five factors and 0.92 for the overall questionnaire; test-retest reliability generated correlations ranging from 0.62 to 0.83 for the five factors [56]. Morin et al. [55] suggest that the ATTID *can* be used to measure attitudes among different populations and allows comparisons over time within the same population.

The ATTID questionnaire has much practical and research utility in attitude research where the researcher is endeavouring to ascertain the general population attitude in relation to people with learning disabilities.

Much of the research on attitude has suggested however that increasing personal contact with people with learning disabilities by supporting them to access education, employment and social activities on an equal footing with everyone else may prove to be the most important and equitable of interventions. Abbott and McConkey [61] argue that positive attitudes follow on from increased social contact, thus a priority should be to provide opportunities for people with disabilities to engage in social contact. Clifford-Simplican et al. [2] recommended further research in the community. They highlight that communities face different challenges in fostering social inclusion depending on their characteristics, e.g. rural versus urban communities, or heterogeneous versus homogenous communities. Different forms of community organizations will likely have different attitudes towards people with learning disabilities that affect social inclusion and hence ascertaining these attitudes is very important, bearing in mind the need to separate attitudes in fact to attitudes in principle.

A research case study exemplar utilizing McConkey et al.'s [62, Appendix 1] *Attitude Questionnaire* and micro-neighbourhood combined with a comparative survey design will be outlined hereunder, which will compare views/attitudes in principle versus views/attitudes in fact. More specifically, the research examined if differences existed in attitudes to people with learning disabilities in the immediate vicinity of a community-home for people with learning disabilities, when compared with those living in a neighbourhood with no such community-homes.

6. Methodology

6.1. Aim

The aim of the current attitude research was to identify community attitudes to people with learning disabilities living in the community in Southern Ireland.

6.2. Research design

The current study utilized a comparative descriptive design, combining a random survey and a micro-neighbourhood sample. There are many research designs in attitude research and one of the authors would recommend to showcase an exemplar of attitude research is a comparative descriptive design when ascertaining attitudes to people with learning disabilities living in the community. This design has utility and practical application when endeavouring to compare the attitudes of two groups within the population under study. In line with the importance of researching attitude, the rationale behind using a micro-neighbourhood design and a simple random survey design was to ascertain true attitudes (views in fact as opposed to views in principle), as evidenced in the literature review.

This comparative descriptive design incorporates a micro-neighbourhood design [63; **Figure 1**] and a simple random survey design. A micro-neighbourhood is defined as surveying the houses surrounding a target house(s), that is, community-home for people with learning disabilities. The researcher using this design is required to survey two houses on either side of the target house on the same side of the street; the five closest houses across the street and the three closest houses behind the target house ($n = 12$). If the target house deviates from this definition in one respect or another, e.g. if houses did not exist behind the target house, the sampling frame should be reduced rather than extended.

6.3. Research sample

A 5% margin of error (the error in estimating a proportion with 95% confidence) is the one most commonly used in research, more especially if, a priori, no such research had been previously carried out. One method of calculating the sample size (n) required for a given some population (N) is to substitute the values in this equation [64, 65]. Five percent margin of error = $1.96 (\sqrt{2500 / N}) \times (1 - n / N)$; however, statistical calculation using statistical software produces a faster and more accurate calculation. The population in the chosen electoral areas was (29,490) therefore 400 was estimated as a representative sample and allowed for a 5% margin of error. A simple random selection was used to proportionally select the sample from each of the electoral areas in the city, using the electoral register

Figure 1. Comparative descriptive design.

(Area 1 = 8191 ; Area 2 = 10,453; Area 3 = 10,846) total ($n = 200$) ($N = 29,490$). The target micro-neighbourhood houses ($n = 158$) were excluded from the random selection. Therefore, the total sample consisted of 358 houses.

6.4. Recruiting and retaining sample

It has been noted that very few people refuse to take part in social research [65]. Therefore, there is a need for extra care when seeking access for research purposes to ensure fully informed consent obtained and full disclosure is made regarding the operationalization of the research process. A letter was sent to prospective respondents prior to the survey, explaining the rationale, aims and objectives of the research. The research information sheet explained how the final report would benefit services in the planning of future of services in the community for people with learning disabilities. The respondents were informed that the findings of the research would be made available to them if such a request was made.

6.5. Ethical approval

Ethical approval was sought from the university where the research was supervised and from main service provider for people with learning disabilities in a city in the South East of Ireland.

6.5.1. Anonymity and confidentiality

Assurances of confidentiality were conveyed in writing both in the research information sheet that was left with respondents and in the letter that was sent to participants prior to the survey being carried out. Participants were reassured that information would be analysed as group data so that individuals could not be identified by their responses and questionnaires were assigned number codes for statistical purposes only.

7. Instrument

The current research utilized a structured questionnaire developed by McConkey [62] with validated psychometric properties. The principal components analysis of all measures of attitude to people with learning disabilities was used in this questionnaire [27]. The questionnaire uses a mix of closed (Likert scales) and open questions to ascertain participants' attitude to people with learning disabilities living in the community. Four main factors or groupings of attitude measurement were used, e.g. contact with people with learning disabilities; interest in having more information about people with learning disabilities; knowledge of learning disabilities and the final factor consisted of questions to do with reactions to meeting people with learning disabilities. McConkey [62, 27] theorized that the data generated from these four aspects of attitude are relatively independent of each other, and consequently, if researchers require a composite picture of attitude, questions from each category are a requisite. Furthermore, Oppenheim [66] theorized that in attitude

research, the more specific and personal questions were to respondents, the more likely they were to give consistent and comprehensive replies.

8. Data collection

A standardized formal interview using a structured questionnaire was used in this research, as interviews tend to have a high response rate and offer the opportunity to correct misunderstanding with regard to questions. The questionnaire enabled the interviewer to carry out ratings while controlling for incompleteness. Interviews are more successful with respondents who have a reading or language difficulty and thereby can aid response rate [67].

8.1. Recruitment and response rate

It is important that the sample is representative of the population, and if a large percentage do not respond, the sample may become biased. The accepted cut-off response rate for surveys is 65% [67, 68]. In this research, an advance participation invite notification was sent to respondents. The letter included an explanation about the research; how respondents were chosen; confidentiality and anonymity; and the time that it would take to complete the questionnaire. Other strategies implied to deal with response rate were careful pilot work in order to ensure that the design of the questionnaire was delivering similar answers from respondents. Additionally, a cover letter was sent to all respondents and an incentive such as a copy of the results of the survey, if so requested, was assured by the administrators of the questionnaire. In the case of non-response, where people refused, or had moved away or were on holidays, a substitute with matching characteristics was used. The administrators also endeavoured to find out whether the reasons for non-response were somehow connected with the topic of the research. Both research administrators were afforded interview skills training as interview skills were considered an important part of the interview response rate. This training enabled the administrators together with the researcher to check responses and related problems by monitoring the completed questionnaires by comparing the results obtained by various interviews for patterned differences.

9. Data analysis

The completed questionnaires were collated and coded using a statistical package for the social sciences [69]. In phase 1 of the data analysis, frequencies of responses and cross tabulation of individual questionnaire items were calculated for the purpose of specific demographic information and the results were displayed using tables. In phase 2 of the data analysis, observations from the micro-neighbourhood and the random selection were compared. The chi-square inferential statistical method was used to examine the potential association between categorical variables, that is, between the micro-neighbourhood sample and the random sample, in each of the following categories: demographic details; social networks and activities;

contact; problems or difficulties for a neighbourhood; benefits for neighbourhood; knowledge of local centres for people with learning disabilities; type of people who attended these centres; knowledge of community-homes for people with learning disabilities; community care policy; weekend schemes and general comments. These tests were conducted to identify associations that existed between samples and each of the individual factors in the outlined categories. Where cell sizes were too small in '2 × 2' tables, that is, when the expected cell count was found to be less than five, Fishers exact probability test was applied. For all two by two tables, Yates [70] continuity correction was used in order to accommodate for the use of a continuous probability distribution as an approximation to the discrete probability distribution [71]. The qualitative data from the verbatim comments made by respondents were not content analysed due to time constraints, but verbatim comments were included in the results and appendices. Where percentages did not add to 100%, this was due to rounding, multiple answers and exclusions of the 'don't knows'. Only the main findings will be discussed in the current chapter.

10. Results

10.1. Demographic attributes of both samples

Across both samples, 470 interviews were attempted and 358 completed. This was made up of 158 respondents in the micro-neighbourhood and 200 respondents in the no-community-home sample. Of the respondents, 148 were males, 210 females and this included other combinations of persons, e.g. wife, mother and widow. Age, marital status, education, work patterns, number of children under 16 years and type of living accommodation were also obtained (Table 1).

Chi-square tests were applied to both samples, and each demographic characteristics, to see if significant associations existed. The average interviewee was between 20 and 59, and there was a significant association between the two areas and age ($p \leq 0.05$). The majority of those near a community-based residence were aged 20–29 years, followed by 49–59 age band, whereas the age range of those living in the contrast area was 49–59 years. A higher proportion of those living in the no-community-home sample were aged 60 years or over. There was no significant difference between the proportion of females versus males in both samples, indicating an equal distribution of gender ($p > 0.05$). The majority of respondents 58% (116) in the no-community-home sample left school at 15 years of age. A significant association ($p < 0.001$) between the community-home sample and education was found. There was a significant difference ($p = 0.001$) between samples with regard to marital status, a higher percentage (30%) single in the community-home location as opposed to 3% in the contrast sample. No significant associations between samples were obtained on either, length of time people resided in the neighbourhood ($p > 0.05$) and respondents' occupation ($p > 0.05$). There was significant differences between the micro-neighbourhood and the random samples with respect to having children under 16 years. A higher percentage of respondents in the community-home sample had children under 16 ($p < 0.01$). Type of accommodation differed between samples

Description	Community-home (n = 158)		No-Community-home (n = 200)		Chi square	P value
	n	%	n	%		
Age						
<20	4	2.6	8	4		
20–39	65	41.7	55	27.8	8.441	.038
49–59	58	37.2	82	41.4		
60+	29	18.6	53	26.8		
Gender						
Male	62	39.2	86	43.0	.371	.542
Female	96	60.8	114	57.0		
School (Leave school at)						
15	47	29.9	116	58.0	28.164	<.001
Go to higher level	79	50.3	63	31.5		
Go to college/university	31	19.7	21	10.5		
Marital status						
Single	20	2.7	60	30.0		
Married	124	78.5	23	61.5	15.646	.001
Widowed	12	7.6	14	7.0		
Separated	2	1.3	3	1.5		
Living in						
Neighbourhood < 1 year	10	6.3	6	3.0		
1–2 years	8	5.1	11	5.5	3.17	.365
3–5 years	9	5.7	17	8.5		
Over 5 years	131	82.9	166	83.0		
Occupation						
Working full-time	65	41.1	61	30.5		
Part time	22	13.9	34	17.0		
Full-time student	3	1.9	6	3.0	9.696	.084
Unemployed	3	1.9	13	6.5		
Housewife	43	27.2	48	24.0		
Retired	22	13.9	38	19.0		
No. of children <16						
Yes	80	51.3	114	66.3	7.377	.007
No	76	48.7	57	33.1		

Description	Community-home (n = 158)		No-Community-home (n = 200)		Chi square	P value
	n	%	n	%		
Accommodation (Type)						
Rented	15	9.7	43	22.6	9.185	.002
Owned/bought by you	139	90.3	147	77.4		
Private	137	89.5	130	78.3		
Council	16	10.5	36	21.7		

Table 1. Characteristics of community-home and no-community-home samples.

($p < 0.01$), with a higher percentage in the community-home sample owning or having owned their house, whereas in the no-community-home sample, a higher percentage rented and/or lived in council housing.

10.2. Contact with people with learning disabilities

In the questionnaire, all respondents (random and micro-neighbourhood) were asked if they had contact with people with learning disabilities living in the community (**Table 2**).

A significant association between samples and amount of contact emerged ($p < 0.001$). In the micro-neighbourhood sample, 41% (65) of respondents reported seeing people with learning disabilities in their community, this compared with 13% (25) in the no-community-home sample, but regular contact was low in both samples. Respondents were then asked if these people had a learning disability (**Table 3**).

In **Table 3**, the analysis of the data yielded statistically significant differences between the proportion of the two samples who had contact with people with learning disabilities ($p < 0.001$). In the micro-neighbourhood sample, 96% (108) maintained they had contact, but only 64% (48) of the other sample had such contact.

The type and quality of contact with people with learning disabilities from neighbours was not strongly evidenced, 52% (82) in the community-home area and 64% (128) in the corresponding sample stated they had no real contact (**Table 4**). The amount of regular contact in both areas is similar, contradicting what had been apparent in **Table 3**, in which respondents maintained that they had contact with people with learning disabilities 96% (108) in the micro-neighbourhood home and 64% (48) in the no-community-home sample.

In the micro-neighbourhood, that is, respondents living next door or in the vicinity of community-home findings from the data (**Table 5**) on contacts revealed the amount of contact they had with people with learning disabilities over a week, a month and year. Ninety-three percent (31) of the respondents stated they had seen people with learning disabilities around the neighbourhood; 77% (109) of respondents who replied to this question maintained that they had seen them in the last week and 56% (79) stated they had talked to them outside of the community-home. Respondents were then asked such contact was made and the results are presented in **Table 5**.

Contact...	Community-home (n = 158)		No-Community-home (n = 200)		Chi-square	P value
	n	%	n	%		
No contact with people with disabilities	46	29.1	124	62.0		
Seen people with disabilities people around the area	65	41.1	25	12.5	50.815	<.001
Occasional meetings people with disabilities	20	12.7	16	8.0		
Regular contact with people with disabilities	27	17.1	35	17.5		

Table 2. Percentage of respondents reporting contact with people with disabilities.

Are they people with learning disabilities?	Community-Home (n = 158)		No-Community-Home (n = 200)		Chi-square	P Value
	n	%	n	%		
Yes	108	95.6	48	64.0	31.853	<.001
No	4	3.5	25	36.0		

Table 3. Percentage of respondents reporting they had contact with people with learning disabilities.

Contact...	Community-home (n = 158)		No-Community-home (n = 200)		Chi-square	P value
	n	%	n	%		
No real contact with people with learning disabilities	82	51.9	128	64.0		
Just seen people with learning disabilities in the community	21	13.3	16	8.0	6.354	.096
Met and talked with people with learning disabilities	23	14.6	21	10.5		

Table 4. How contact was made with people with learning disabilities.

Of the 62 respondents (**Table 6**) who answered this question, 29% (18) people stated that people with learning disabilities approached them. Other than this, contact was made at other social outlets like, at mass, at the shops and social outings. The findings show no dramatic increase in meaningful contact.

Contact		Yes		NO		PW		PM		PY	
		n	%	n	%	n	%	n	%	n	%
Seen people with learning disabilities in the area	(n = 141)	131	92.9	10	7.1	109	77.3	12	8.5	8	5.7
Talked to people with learning disabilities in the community	(n = 141)	79	56.0	62	44.0	61	43.3	9	6.4	10	7.1
Visited community-home of people with learning disabilities	(n = 141)	27	19.1	114	80.9	3	2.1	2	1.4	21	14.9
Have people with learning disabilities visited your house	(n = 141)	20	14.2	121	85.8	1	0.7	4	2.8	14	9.9
Have you had any other contact with people with learning disabilities	(n = 138)	27	19.6	111	80.4	10	7.2	4	2.9	2	1.4

PW = Per Week; PM = Per Month; PY= Per Year

Table 5. Micro-neighbourhood sample and contact with people with learning disabilities.

How was contact made (n = 62)	N	%
People with learning disabilities approached you	18	29.0
You approached people with learning disabilities	15	24.2
You were introduced to people with learning disabilities by staff from a community-home	2	3.2
Other type of contact		
Mass	10	16.1
Shops	6	9.7
How was contact made ...		
Mutual contact	4	6.5
Social outing	3	4.8
Bus stop	2	3.2
Mass/shops	1	1.6
Taxi	1	1.6

Table 6. Micro-neighbourhood and how contact with people with learning disabilities was made.

11. Summary of main findings

The main findings do highlight some important variations between samples. These domains include the following variables and are illustrated in **Table 7**.

There were significant differences between the two samples, with regard to the following variables. There were more people over the age of 60, more single people, more rented and

Demographic attributes of both samples	X	XXX	XXX	XX	XX
	Age	School	Marital Status	Children	Accommodation
Social Networks and activities	XXX Public Houses				
People reporting contact with people with learning disabilities	XXX Seen them around				
Are they people with learning disabilities	XXX Yes				
Problems or difficulties for a neighbourhood	XXX Yes, it would				
Problems that respondents suggested	XX Isolated	XXX Teased	XXX Victimised/ picked on	XXX Danger to children	
	XX Not Adequate Care/Supervisor	XXX Noisy/ created disturbance	XXX Property value	XXX Violent/irresponsible	
Benefits	X General Awareness		XXX Children would become more aware		
Centres for people with learning disabilities	XX Lady Lane		X Brothers of Charity	X Rehab	
People who attended these centres	X People with Learning Disabilities				
Knowledge of community-homes for people with learning disabilities	XXX Yes, there is				
Reason why community care policy is good or not	XX They are good neighbours				
Types of activities	XX Visit		XXX Visit your home		XXX Help with outings

Demographic attributes of both samples	X	XXX	XXX	XX	XX
	Age	School	Marital Status	Children	Accommodation
General Comments	X	X	XX	X	XX
	More information	No comment	People get to know them	Fears generally	Good neighbours

X = P < 0.05; XX = P < 0.01; XXX = P < 0.001

Table 7. Community-home and no-community-home. Significant observed differences between community-home and no-community-home samples.

council living accommodation and a higher percentage left school at 15 years of age in the no-community-home sample. A higher percentage of respondents in the community-home sample had more children under 16 years; the majority owned their accommodation and went on to pursue a higher level of education. The community-home sample reported seeing people who were ‘disabled’ [with a learning disability] in their community, more often than did the contrast sample. With regard to view that a community-home opening would pose problems or difficulties, 13% of respondents in the no-community-home sample reported that this could result, whereas only 1% related negativity to this question in the community-home sample.

More people in the no-community-home sample registered concern with regard to the following variables: isolation, being teased and made fun of, being victimized, posing a danger to children, not having adequate care, being noisy, and creating a disturbance, would have an adverse effect on property values and could be violent or irresponsible. Under 50% of the community-home sample registered general awareness as a major positive for people with learning disabilities. They further alluded to the fact that children would become more aware and knowledgeable about people with learning disabilities.

Interestingly, more people in the no-community-home sample were able to identify a local service provider than in the community-home sample. Nonetheless, respondents in the community-home sample knew that people with learning disabilities attended special centres and were able to identify the name and location of a community-home in their neighbourhood, whereas a significantly less people knew of community-home in the no-community-home sample. A higher proportion of people in the community-home sample stated that people with learning disabilities were good neighbours. In the no-community-home sample, more people were interested in helping out with activities such as visiting people with learning disabilities in their homes, inviting them to their home and helping out with social outings.

12. Discussion

As evidenced by research studies including the Irish study exemplar in this chapter, true social integration has not been fully achieved for people with learning disabilities. It has been suggested that contact, personal goal setting, relationships with the staff for people with learning

disabilities and the wider community may be the key to changing attitudes and thus enhancing genuine integration [61, 72]. Thus, the micro-neighbourhood design combined with the random survey allowed the views of those who may have been expected to have contact with people with learning disabilities as living in the direct neighbourhood of a community-home to be compared with the general population.

It seems that significant contact with community-homes is very limited, which is supported by Abbott and McConkey [61, 72, 73]. While respondents maintained that they had contact with people with learning disabilities, with 96% reporting contact in the micro-neighbourhood and 64% in the no-community-home sample, this was not reflected in the type and quality of contact. Only 48% of the community-home sample and 36% of the no-community-home sample stated they had 'real contact', implying that significant contact is lacking.

The foregoing highlights the point that proximity to a group home does not necessarily imply neighbourly contact. The evolution of community living options for people with learning disabilities has therefore to be accompanied by an awareness of the prevailing social attitudes and the amount of contact people with learning disabilities have with neighbours and the wider community.

When one considers that those in the general population were more likely to report interest in becoming involved with people with learning disabilities in community-homes, this suggests that this expressed wish is an abstract statement that does not occur in reality for those living in the micro-neighbourhood in closer proximity to people with learning disabilities. The contact is superficial and reflects a major deficit in the level of relationships. Therefore, when compared with the positive attitudes expressed, it seems there is evidence of a discrepancy between attitudes in principle and attitudes in fact. Ichheiser's [4] theory serves to explain how people living in areas where there were no-community-homes express no reservations about having people with learning disabilities as neighbours ('*views in principle*'); whereas '*view in fact*' surface when a community-based home for people with learning disabilities is next door; not in my backyard or the NIMBY effect.

While the findings show significant differences between the two samples, the research cannot control or elucidate the various possible factors that may have contributed to these differences. In general, it is apparent that the results provide some evidence of the level of awareness and attitudes that exist and are illuminating in that it leaves many questions yet to be answered. These include questions relating to the determinants of social inclusiveness and more importantly quality of life issues for people with learning disabilities living a normal life in the community. It begs one to question the normality and the adequacy of such services in seeking to achieve a normal life in such community settings. The value of building relationships within communities is pivotal, creating a sense of community and changing perceptions relating to disability. Ichheiser [4] suggested that:

The only reasonable thing we can do about illusions and misinterpretations which are deeply rooted in the nature of our human existence is to neutralise their too disturbing effects by increasing awareness within our social perception [p. 35].

The hope still rests on the endeavours of learning disability service providers and government agencies in promoting neighbourhood relationships and social inclusiveness. As people

with learning disabilities are now living in communities, it is essential that social integration policy continues to be challenged and requires ongoing engagement with a broader economic and political rhetoric [74].

The lack of evidence-based research relating to natural supports and independent living is a significant obstacle to the development of policy and services in this area. Additional studies and data collection are required to address this deficit. Service providers and how they deliver services can also present barriers to network formation and social inclusion for people with learning disabilities. These barriers could arise from staffing issues, staff practices and the priority given to care over community participation. To achieve true social integration, however, the onus rests with service providers and government agencies to identify these barriers and address them. Accurate, update knowledge on the attitudes of the community towards people with learning disabilities must be elucidated before such attitudes can be improved.

13. Limitations

The research may have over-simplified public attitudes, but future research in this area could be directed at the development of a more sensitive and flexible methodology capable of assessing a wider range of attitudes, using an instrument with 5, 6 or 7 point Likert scales.

It is important to highlight that the study distinguishes between areas with and without community-homes for people with learning disabilities; this in fact was not the case as in the random sample community-homes for people with learning disabilities could have existed in the surrounding districts.

Due to time constraints, it was not possible to perform additional statistical tests to ascertain whether positive attitudes were a function of or were mediated by social class or educational record and to what degree age influenced attitude. This would have involved performing further multi-variate analysis on such variables. Future studies could also address the idea of performing content analysis using ethnography on the qualitative data from this research. The research focused on social contact, but assessment of the quality of the relationships involved was beyond the scope of the present study. Assessment in this regard could look at using discriminant analysis in order to detect root differences between samples.

14. Conclusion

For people with disabilities to have equal opportunities to participate and to contribute as equal citizens, society needs to accept that munificence extends to all members of society and that difference is recognized and valued [74].

It was identified that people with learning disabilities were functionally, but not socially integrated in communities. Attitudes were very positive towards people with learning

disabilities, with only a minority expressing ‘stereotypical’ concerns. However, clear differences were identified in the attitudes of those in the random sample as opposed to those in the micro-neighbourhood survey. Those who lived near community-homes had more positive attitudes, whereas those in the random sample, while expressing positive attitudes, did not want community-homes in their locality.

It was evident from this study that attitudinal research that combines a micro-neighbourhood and a random survey gives a true picture of attitudes in fact as opposed to attitudes in principle. Hence, a more sensitive and flexible methodology capable of measuring a wider range of attitudes using the design recommended in this chapter has practical utility as a methodological approach. Attitudes cannot be expected to remain static and on-going research is required to monitor and re-evaluate such changes, which will contribute to more informed discussions and more effective planning of services and meaningful socially inclusive and self-determined lifestyles for people with learning disabilities.

Appendix 1. Attitude questionnaire

	No. Code	<input type="text"/>
	Electoral Area Code	<input type="text"/>
Minutes	<input type="text"/>	
	Interviewer Code	<input type="text"/>
<div>General Section</div>		

On behalf of ... We are carrying out a survey about people with learning disabilities living in this neighbourhood. Can I have about 15 minutes of your time to answer some simple questions?

1. How long have you been living in this neighbourhood?
- a) Less than 1 year

b) 1–2 years

c) 3–5 years

d) Over 5 years

2. How many families would you know by name within 15 minutes walking distance of your house?

- a) None
- b) 1 or 2
- c) 3 to 5
- d) 6 to 15
- e) 16+

3. How many of these families are related to you?

- a) None
- b) 1 or 2
- c) 3 to 5
- d) 6 to 15
- e) 16+

4. Would you say that, in general, you have:

- a) Only occasional contact with your neighbours
- b) Some contact now and again with your neighbours
- c) Frequent and regular contact with your neighbours

5. What activities are you regularly involved in present within this area, that is, you could walk to them within 15 minutes. Do you go to:

	Yes	No
a) Any sports in this area		
b) Any pubs in this area		
c) Bingo and dances		
d) Any churches in the area		
e) Any meetings at school		
f) Residents' association or neighbourhood watch		
g) Any other activities please specify		

6. Is there a centre for people with learning disabilities in your city.

- a) No, there is not
- b) Don't know
- c) Yes, there is

A whereabouts is it?

PROBE are there any other centres? (For example)

--

What sort of people attend (use their all wording for the centre)

7. Can I ask what contact you will have had with people with learning disabilities in your neighbourhood?
 - a) No contact
 - b) Seen them around
 - c) Occasional meetings
 - d) Regular contact
- 7b. Are they people with learning disabilities? Yes or no.
8. Thinking of people with learning disabilities in general, Can I ask what contact you have had with people with learning disabilities?
 - a) Children
 - b) Adults
 - c) No real contact just seen them around
 - d) Met and talked with them
 - e) Regular contact
9. There is now a national policy of having people with learning disabilities living wherever possible within the local community. Do you think that?
 - a) On the hall, this is a good policy
 - b) Not so good policy
 - c) You have no opinion one way or the other (go to question 10)

If the person answer is 1 or 2; then ask why is this?

10. Is there a house that is occupied by a group of people with learning disabilities, physical disabilities or mental health problems in this neighbourhood?
 - a) Yes, there is
 - b) I don't know
 - c) No, there is not

Go to section 2 is interviewing areas with a group home

Then section 4

or

Go to section 3 is interviewing areas with no group home,

Then go to section 4

SECTION 2 AREAS WITH A GROUP HOME

11. Whereabouts is it?

- If not the house ask (are there people with learning disabilities)?
- Are you aware of any other houses for people with learning disabilities in this neighbourhood?
- How many of the people would you know by name?
- How many of the staff would you know by name?

12. What contact have you had with people with learning disabilities from the home?

		Past					
		No	Yes	no	Week	Month	Year
a	Have you seen them around the neighbourhood?	1	2	3			
b	Have you talked to them outside?	1	2	3			
c	Have you been into their home?	1	2	3			
d	Have any being into your house?	1	2	3			
e	Have you had any other contact?	1	2	3			

13. How was the contact made?

- You approach the person with a learning disability
- They approached you
- Introduced by staff
- Other/Can't recall

14. What contact have you had with the staff who work in the home?

		Past					
		No	Yes	no	Week	Month	Year
a	Have you seen them around the neighbourhood	1	2	3			
b	Have you talked to them outside	1	2	3			
c	Have you been into their home	1	2	3			
d	Have any being into your house	1	2	3			
e	Have you had any other contact	1	2	3			

15. How was the contact made?

- a) You will approach the staff person
- b) They approached you
- c) Introduced by person with a learning disability
- d) Other/Can't recall

15b. Has anyone else in your household had contact with people from the group home?

- a) yes
- b) No

If yes, who?

What contact have they had?

16. Do you think that there have been any problems or difficulties in the neighbourhood resulting from people with learning disabilities occupying that house?

- a) yes
- b) No

Probe: And others?

17. Can I just check some (other) problems that other people have suggested in previous surveys? I'd like to know if you have found any of these things to be at problem with regard to the home for people with learning disabilities in your neighbourhood.

- a) Yes that has been a bit of a problem
- b) No problem that I am aware of
- c) Can't decide

A	People with learning disabilities being teased, made fun of or jeered at	1	2	3
B	People with learning disabilities and not receiving adequate professional care and supervision	1	2	3
C	They have been isolated and just kept to themselves	1	2	3
D	They have been victimized, picked on or taken advantage of	1	2	3
E	They have been danger or threat to children or others	1	2	3

F	They have made people embarrassed. People haven't known what to say to them or how to react to them	1	2	3
G	People with learning disabilities have been noisy and created disturbances	1	2	3
H	The property value of neighbourhood houses has dropped or	1	2	3
I	People with learning disabilities have been violent or irresponsible	1	2	3

18. Do you think there have been any benefits for the neighbourhood in having these people living in your area?

a) None that you can think of

b) Yes, there have been. Can you say what these are?

19. There is talk of a scheme in which people are paid to have a person with learning disabilities stay at their house for a weekend, would you:

a) Be interested in having a person staying with you

b) Be interested but would want to know more about the scheme first

c) Be interested but it's not possible at present

a) Not interested

Go to Section 4

Section 3: Areas with No Group Home

20. If a house for three or four people with learning disabilities with one or two care staff started up in your neighbourhood, for example, at that house over there/down the road/round the corner, which is vacant, do you think that this would give rise to any problems in the neighbourhood?

a) No, it wouldn't

b) Yes, it would

What might these problems be?

21. Can I just check some (other) problems that other people have suggested in previous surveys. I'd like to know if you think there would be a risk of that problem arising in your neighbourhood.

- a) That could be a risk in this neighbourhood
- b) No risk that you can think of
- c) Can't decide

A	People with learning disabilities being teased, made fun of or jeered at	1	2	3
B	People with learning disabilities and not receiving adequate professional care and supervision	1	2	3
C	They have been isolated and just kept to themselves	1	2	3
D	They have been victimized, picked on or taken advantage of	1	2	3
E	They have been danger or threat to children or others	1	2	3
F	They have made people embarrassed. People haven't known what to say to them or how to react to them	1	2	3
G	People with learning disabilities have been noisy and created disturbances	1	2	3
H	The property value of neighbourhood houses has dropped or	1	2	3
I	People with learning disabilities have been violent or irresponsible	1	2	3

22. Do you think there could be any benefits for the neighbourhood if a group of people with learning disabilities moved into the area?
- a) None that you can think of
 - b) Yes there might. Can you say what these might be?
23. There is talk of a scheme in which people are paid to have a person with learning disabilities stay at their house for a weekend, would you?
- a) Be interested in having a person staying with you
 - b) Be interested but would want to know more about the scheme first
 - c) Be interested but it's not possible at present
 - d) Not interested

Section 4

Areas with a group home

As you know people with learning disabilities can do with some extra help, if you were asked, would you be interested in:

24. Areas with a group home: As you know, people with learning disabilities can do with some extra help. If a group home for people with learning disabilities were to move into your area and the staff living with them asked you to help, would you be interested in:

-
- a) Taking a person with a learning disability from the home along with you on an outing once in a while for example to church, shopping etc.
 - b) Goals we ~home to visit them
 - c) Helping out staff in an emergency.
 - d) Having a person with a learning disability come to your home on a visit are for a cup of tea
 - e) Go along to an open day or a coffee evening in the house
 - f) Make a point of taking to the person if you saw them around the neighbourhood are went shopping etc.
-

Finally, can I ask some questions about yourself?

25. Are you aged:

- a) <20
- b) 20 to 39
- c) 40 to 59
- d) 60+

26. Did you leave school at:

- a) 15 years
- b) Go onto a higher level (leaving certificate)
- c) Go to College, University

27. Are you:

- a) Working full-time
- b) Part time
- c) Full-time student
- d) Unemployed
- e) Housewife
- f) Retired

28. Are you:

	Yes	No
1. Single		
2. Married		
3. Have you a children under 16 years		

29. Is your house/accommodation

- a) Rented
- b) Owned or bought out by you

Is it

- a) Private
- b) Council

30. Have you ever been involved in any form of voluntary work?

- a) No
- b) Yes, in the past
- c) Yes, at present

31. Any further comments you would like to make about people with learning disabilities living in the community.

NB Hand-over ‘Research Information Sheet’ and ‘Thank You Sheet’ to Participant(s)

Professor Roy McConkey (1983) © Permission given to use and/or adapt instrument

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References

- [1] Lemay RA, Deinstitutionalization of people with developmental disabilities: A review of the literature. *Canadian Journal of Community Mental Health*. 2009;**28**(1):181-194
- [2] Clifford Simplican S, Leader G, Kosciulek J. Defining social inclusion of people with intellectual and developmental disabilities: An ecological model of social networks and community participation. *Research in Developmental Disabilities*. 2015;**38**:18-29
- [3] Debenham L. Social Inclusion and Learning Disabilities [Internet]. 2016. Available from: <http://www.aboutlearningdisabilities.co.uk/social-inclusion-learning-disabilities.html> [Accessed: 20-December-2016]
- [4] Ichheiser G. *Appearances and Realities*. San Francisco: Jossey-Bass; 1949
- [5] Quass M, Fraser K. *Beyond the Ramp: A National Approach to Education and Training in the Adult and Community Education Sector for Adults with Disabilities*. Australia: Australian Association of Adult and Community Education. AAACE/CSOAE Disability Project; 1993
- [6] European Commission. Progress Report on the Implementation of the European Disability Strategy (2010-2020) European Commission Brussels [Internet]. 2017. Available from: <http://ec.europa.eu/social/main.jsp?catId=1137> [Accessed: 2017-10-2017]
- [7] Clarke ABB, Clarke AM. Cognitive changes in the feeble minded. *British Journal of Psychology*. 1954;**45**:173-199
- [8] International Classification of Diseases (ICD) World Health Organisation. Geneva; 2010, retrieved 4 April 2017
- [9] Morris J. *Pride against Prejudice*. London: The Women's Press; 1991
- [10] Goffman E. *Asylums: Essays on the Social Situation of Mental Patients and other Inmates*. Harmondsworth: Penguin; 1961
- [11] King RD, Raynes NV, Tizard J. *Patterns of Residential Care: Sociological Studies in Institutions for Handicapped Children*. London: Routledge, Kegan Paul; 1971
- [12] Grunerwald K. The Intellectually Handicapped in Sweden- New Legislation in a Bid for Normality. *Current Sweden*. 1968;**345**:1-10
- [13] Bank Mikkelsen NE. A Metropolitan area in Denmark: Copenhagen. In: Kugel R, Wolfensberger W, editors. *Changing Patterns in Residential Services for the Mentally Retarded*. Washington: Presidents Committee on Mental Retardation; 1969. 227-254
- [14] Wolfensberger N. *The Principle of Normalisation in Human Services*. Toronto: National Institute of Mental Retardation; 1972. Worldwide Process of Disability Reform. Available at: <http://www.unhchr.ch/>
- [15] Wolfensberger W, Thomas S. *PASSING (Program Analysis of Service Systems' Implementation of Normalization Goals): Normalization Criteria and Ratings Manual*. 2nd ed. Toronto: National Institute on Mental Retardation; 1983

- [16] National Disability Authority. A National Survey of Public Attitudes to Disability in Ireland. Dublin: National Disability Authority; 2011
- [17] Verdonschot MML de Witte LP, Reichrath E, Buntingx, WHE, Curfs LMG. Community participation of people with an intellectual disability: A review of empirical findings. *Journal of Intellectual Disability Research*. 2009;**53**(5):303-331
- [18] Forrester-Jones R, Carpenter J, Coolen-Schrijner P, Cambridge P, Tate A, Beecham J, Overmars-Marx T, Thomese F, Verdonschot M, Meininger H. Advancing social inclusion in the neighbourhood for people with an intellectual disability: An exploration of the literature. *Disability & Society*. 2013;**29**:255-274
- [19] Quinn G, Doyle S. Getting a life—living independently and being included in the community: A legal study of the current use and future potential of the EU Structural Funds to contribute to the achievement of Article 19 of the United Nations Convention on the Rights of Persons with Disabilities. Report to the Office of the United Nations High Commissioner for Human Rights, Regional Office for Europe; 2012
- [20] Perry J, Allen DG, Pimm C, Meek A, Lowe K, Groves S, et al. Adults with intellectual disabilities and challenging behaviour: The costs and outcomes of in- and out-of-area placements. *Journal of Intellectual Disability Research*. 2013;**57**:139-152
- [21] Bigby C. Known well by no-one: Trends in the informal social networks of middle-aged and older people with intellectual disability five years after moving to the community. *Journal of Intellectual and Developmental Disability*. 2008;**33**(2):148-157
- [22] Milner P, Kelly B. Community participation and inclusion: People with disabilities defining their place. *Disability and Society*. 2009;**24**(1):47-62
- [23] Robertson J, Emerson E, Gregory N, Hatton C, Kessissoglou S, Hallam A, Linehan C. Social networks of people with mental retardation in residential settings. *Mental Retardation*. 2001;**39**:201-214
- [24] Lippold T, Burns J. Social support and intellectual disabilities: A comparison between social networks of adults with intellectual disability and those with physical disability. *Journal of Intellectual Disability Research*. 2009;**53**(5):463-473
- [25] Ritchie P. Public Attitudes to People with a Learning Disability, and How to Influence Them [Internet]. 1999. Available from: <http://www.gov.scot/Resource/Doc/1095/0001679.pdf> [Accessed 10-January-2017]
- [26] Meyers F, Ager A, Kerr P, Myles S. Outside Looking In? Studies of the community integration of people with learning disabilities and society. *Disability & Society*. 1998;**13**(3):389-413.
- [27] McConkey R. Who Cares? Community Involvement with Handicapped People. London: Souvenir Press; 1987
- [28] Hernandez B, Keys C, Balcazar F. Employer attitudes toward workers with disabilities and their ADA employment rights: A literature review. *Journal of Rehabilitation*. 2000;**66**(4):4-16

- [29] Zimbardo P, Ebbessen EB. Influencing attitudes and hanging behaviour. Reading, MA: Addison-Wesley; 1969
- [30] Gellman W. Roots of prejudice against the handicapped. *Journal of Rehabilitation*. 1959;254-256
- [31] Thomas MG. The Royal National Institute for the Blind 1868-1956. London: Royal National Institute for the Blind; 1957
- [32] Wright BA. Physical Disability: A Psychological Approach. New York: Harper; 1960
- [33] Jaffe J. Attitudes of adolescents toward persons with disabilities [thesis]. Columbia University: Teachers College; 1965
- [34] Park CW, Lutz RJ. Decision plans and consumer choice dynamics. *Journal of Marketing Research*. 1982;19(1):108-115
- [35] Massie B. Participation – have we got an Attitude Problem? In: Proceedings of the NDA 5th Annual Conference Civic, Cultural and Social Participation: Building an Inclusive Society (NDA'06) Dublin; 16 November 2006; Ireland. (paper available at www.nda.ie)
- [36] Nowicki EA. A cross-sectional multivariate analysis of children's attitudes towards disability. *Journal of Intellectual Disability Research*. 2006;50:335-348
- [37] Cialdini RB, Petty, RE, Cacioppo JT. Attitude and attitude change. *Annual Review of Psychology*. 1981;32:357-404
- [38] Fossey E. Young children and alcohol. A theory of attitude development. *Alcohol and Alcoholism*. 1993;28:485-498
- [39] Sdorow L. Psychology. Dubuque, IA: W.C. Brown Publishers; 1990
- [40] Wai A, King M, David WK. Attitudes toward people with disabilities: A comparison between health care professionals and students. *International Journal of Rehabilitation Research*. 2006;29:155-160
- [41] Gelber DM. Changing attitudes toward physically disabled persons: Effect of contact knowledge of disability and information exchange. Ann Arbor, 1993 MI; 1993 UMI
- [42] Elmaleh GY. A study of attitudes toward employees with disabilities Ann Arbor: UMI ProQuest Digital Dissertations database. [UMI No. 9973138]
- [43] Hewstone M. Contact and categorization: Social psychological interventions to change inter-group relations. In: Macrae CN, Stangor C, Hewstone M, editors. *Stereotypes and Stereotyping*. New York: Guilford Press; 1996. pp. 323-368
- [44] Pettigrew TF. Intergroup contact theory. *Annual Review of Psychology*. 1998;49:65-85
- [45] Pettigrew TF, Tropp LR. Does intergroup contact reduce prejudice? Recent meta-analytic findings. In: Oskamp S, editor. *Reducing Prejudice and Discrimination 'The Claremont Symposium on Applied Social Psychology*. 2000. pp. 93-114
- [46] Hewstone M. Inter-group contact: Panacea for prejudice? *The Psychologist*. 2003;12(7): 352-355

- [47] Deal M. Aversive disablism: Subtle prejudice toward disabled people. *Disability and Society*. 2007;**22**:93-107
- [48] Allport GW. *The Nature of Prejudice*. Garden City: Anchor Books; 1954
- [49] Antonak RF. Prediction of attitudes towards disabled persons: A multivariate analysis. *The Journal of General Psychology*. 1981. pp 789-884
- [50] Lemon N. *Attitudes and their Measurement*. New York: Wiley; 1973
- [51] National Disability Authority. Literature Review of International Evidence on Attitudes to Disability [Internet]. 2007. Available from: <http://nda.ie/Publications/Attitudes/Literature-Review-of-International-Evidence-on-Attitudes-to-Disability> [Accessed: October 2016]
- [52] Yuker HE, Block JR, Campbell WL. *A Scale to Measure Attitudes Towards Disabled Persons* Albertson. New York: Human Resources Foundation; 1960
- [53] Antonak RF. Development and psychometric analysis of the scale of attitudes toward disabled persons. *The Journal of Applied Rehabilitation Counseling*. 1982;**13**:22-29
- [54] White MJ, Jackson V, Gordon PJ. Implicit and explicit attitudes toward athletes with disabilities. *Journal of Rehabilitation*. 2006;**72**(3):33-40
- [55] Morin D, Rivard M, Crocker A, Boursier C, Caron J. Public attitudes towards intellectual disability: A multidimensional perspective. *Journal of Intellectual Disability Research* [serial online]. 2013;**57**(3):279-292. Available from: [Accessed: 1 April 2017]
- [56] Findler L, Vilchinsky N, Werner S. The multidimensional attitudes scale toward persons with disabilities (MAS): Construction and validation. *Rehabilitation Counselling Bulletin*. 2007;**50**:166-176
- [57] Antonak RF, Harth R. Psychometric analysis and revision of the mental retardation attitude inventory. *Mental Retardation*. 1994;**32**:272-280
- [58] Roberts CM, Lindsell JS. Children's attitudes and behavioural intentions toward peers with disabilities. *International Journal of Disability, Development and Education*. 1997;**44**:133-145
- [59] Henry D, Keys C, Jopp D, Balcazar F. The community living attitudes scale mental retardation form: Development and psychometric properties. *Mental Retardation*. 1996;**34**:149-158
- [60] Burge P, Ouellette-Kuntz H, Lysaght R. Public views on employment of people with intellectual disabilities. *Journal of Vocational Rehabilitation*. 2007;**26**(PT):29-37
- [61] Abbott S, McConkey R. The barriers to social inclusion as perceived by people with intellectual disabilities. *Journal of Intellectual Disabilities*. 2006;**10**(3):175-187
- [62] McConkey R, McCormack B, Naughton M. A national survey of young people's perceptions of mental handicap. *Journal of Intellectual Disability Research*. 1983;**27**:171-183

- [63] Hamilton DL, Carpenter s, Bishop GD. Desegregation of suburban neighbourhood. In: Miller N, Brewer MB, editors. *Groups in Contact: The Psychology of Desegregation*. New York: Academic press; 1984
- [64] Mosteller F, Rourke ERK, Thomas GB. *Probability with Statistical Application*. Reading MA: Addison-Wesley; 1961
- [65] LoBiondo-Wood G, Haber J. *Nursing research. 8th ed: Methods and Critical Appraisal for Evidence-Based Practice*. London: Mosby; 2013; eBook ISBN: 9780323293655
- [66] Oppenheim AM. *Questionnaire Design, Interviewing and Attitude Measurement*. London: Pinter Publishers; 1994
- [67] Ong Ad. *The Practice of Health Services Research*. London: Chapman and Hall; 1993
- [68] Ong AD, Weiss DJ. The impact of anonymity on responses to sensitive questions. *Journal of Applied Social Psychology*. 2000;**30**:1691-1708
- [69] SPSS Inc. Released 1999. *SPSS for Windows, Version 10.0*, Chicago, SPSS Inc
- [70] Yates F. Contingency tables involving small numbers and the chi-squared test. *Journal of the Royal Society Supplement*. 1934;**1**:217-235
- [71] Everitt BS. *The Analyses of Contingency Tables*. 2nd ed. London: Chapman and Hall; 1992
- [72] McConkey R, Collins S. Using personal goal setting to promote the social inclusion of people with intellectual disability living in supported accommodation. *Journal of Intellectual Disability Research*. 2010b;**54**(2):135-143
- [73] McConkey R, Collins S. The role of support staff in promoting the social inclusion of persons with an intellectual disability. *Journal of Intellectual Disability Research*. 2010ba;**54**(8):691-700
- [74] Morris J. *Citizenship and Disabled People*. UK: DRC; 2005