THE EFFECTS OF NEIGHBOURHOOD FACTORS ON ATTITUDES TOWARDS MENTAL HEALTH FACILITIES

BY

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ABSTRACT

The purpose of this research paper is to examine the effects of neighbourhood factors on attitudes towards Mental health facilities. The research hypothesis is that personal attitudes towards mental health are a major determinant of reactions to community mental health facilities. The study conducted by the Canadian Training Institute (CTI) in 1983 provides relevant data on attitudes toward mental health group homes. Attitudes towards mental health group homes were studied using measures of desirability and perceived neighbourhood impacts. In order to test the hypothesis, two sets of relationships were examined; the relationship between facility impact and neighbourhoods; and the relationship between facility desirability and neighbourhoods. The results provide support for the results obtained by Trute and Segal in Canada and Linsky in the United States. The results showed similar socio-demographic profiles and attitudes of potential accepting and rejecting neighbourhoods. Therefore, the conclusions are that attitudes towards mental health group homes vary spatially between different types of neighbourhoods. The results have practical reference because they can help planners locate mental health facilities in locations where public opposition and patient dissatisfaction are minimized.

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CHAPTER 1

INTRODUCTION

1.1 PROBLEM STATEMENT

During the last twenty-five years there has been a shift away from the use of large institutions for the treatment of the mentally ill to community-based institutions. Motives for a move away from institution-based treatment have been therapeutic, based on the view that the well-being of patients is best served by their being part of a normal environment, and economic, based on the desire to achieve reductions in the costs of providing care.

Deinstitutionalization of mental health care has meant that demands are placed on selected communities to act as a host to mental health patients which have traditionally been excluded by society. Obviously, the reaction of local residents is crucial to the success of community care because rejection of the mentally ill is likely to undermine the therapeutic effect of being part of a "normal environment."

My main goal is to examine the relationship between the characteristics of residential neighbourhoods and public attitudes towards mental health facilities. Attitudes are freely expressed statements or rank ordered responses given by individuals responding to questions about their feelings, opinions, beliefs or thoughts toward the impact of mental health group homes with respect to: property values, locational preference, children's safety, and residential character (Canadian Training Institute, 1984, pg. 29).

The basic hypothesis is that personal attitudes towards mental illness are a major determinant of reactions to community mental health facilities. Therefore, the main focus of this research paper will be on the perceptions and attitudes towards

mental health facilities. The literature indicates that individual attitudes towards locating group homes in residential communities are based on influences other than empirical data or first hand experience with the situation. The hypotheses suggested by these propositions warrant testing in order to put the evidence which has already been found in the literature in the context of the Ontario experience (Canadian Training Institute, 1984, pg. 27).

Attitudes towards mental health facilities will be studied using measures of desirability and perceived neighbourhood impacts. Of particular value for this thesis are those studies based on the acceptability of mental health facilities located at different distances from the respondent's residence.

1.2 RESEARCH OBJECTIVES

The purpose of this research paper is to examine the effects of neighbourhood factors on public attitudes towards mental health facilities. This topic is of interest because it would help planners to locate mental health facilities in the best locations without much public opposition or patient dissatisfaction. More importantly, the potential therapeutic value of mental health facilities, as being "community-based" could be at stake if residents continue to demonstrate rejecting attitudes.

The studies conducted by the Canadian Training Institute (CTI) in Ontario will provide relevant data for this research paper. Information on individual attitudes was collected in telephone interviews, using a prescribed questionnaire (Canadian

Training Institute, 1984, pg. iv).

Evidently, the problems resulting from deinstitutionalization have in part to do with the neighbourhood in which a mental health facility is located and the public reactions to the mentally ill in the neighbourhood. Since the community plays a vital role in the success or failure of a facility, it will be determined which communities are likely either to accept or reject neighbourhood mental health facilities. Rejecting neighbourhoods have been characterized as having stable populations, low population density, predominantly single-family housing, high proportion of families, high income levels, and homogeneity in terms of race, class and educational background. On the other hand, accepting neighbourhoods are characterized as those with relatively transient populations, high population density, mixed housing stock, few family based households, low levels of social cohesion, and low income levels. In many respects these distinctions correspond to the differences between the central city and the suburbs (Taylor et. al., 1984, pg. 43).

The literature shows three sets of factors to be important determinants of beliefs and attitudes towards mental health facilities: facility characteristics, neighbourhood characteristics, and personal characteristics (e.g., Dear and Taylor, 1982). Even though, all three of these factors will be reviewed, my analysis will focus on neighbourhood characteristics. Ultimately, these factors will contribute to an overall picture of why there are different attitudes towards mental health facilities in different neighbourhoods.

The physical and social structure of a neighbourhood will be analyzed. The physical characteristics of a neighbourhood includes: community homogeneity,

community stability, environment quality, land-use mix, and population density. The social structure of a neighbourhood includes: economic status (high, medium, low), ethnic heterogeneity, neighbourhood transience, scarcity of children, and sex ratio. In the context of my thesis it will be shown that because of the above factors, there are important variations in neighbourhood reactions to mental health facilities (Dear and Wolch, 1987).

The first factor which will be reviewed is facility characteristics. The size, design, and degree of noxiousness are the three main variables of facility characteristics. The second factor that will be reviewed is personal characteristics when examining attitudes towards mental health facilities. There are three subsets of personal characteristics: demographic variables, socioeconomic variables, and belief variables and values. The demographic characteristics are measured by four variables: sex, age, marital status, and number of children in certain age groups. The socioeconomic status characteristics are measured by education level, occupational status, household income and tenure status. The belief variable includes: personal traits and values (Smith, 1988).

1.3 ORGANIZATION OF THESIS

The remainder of the thesis consists of four chapters. Chapter Two provides a literature review covering such topics as the history of community mental health facilities, deinstitutionalization, and characteristics of accepting and rejecting neighbourhoods. The third chapter describes the research design, the data source

and the methods of analysis. The analysis chapter follows and contains the statistical results from the testing of the research hypothesis. Finally in Chapter Five, the findings of the study are summarized, possible new findings are mentioned, and planning implications are considered.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Over the last twenty-five years a large amount of literature has been devoted to the study of attitudes towards mental health facilities. The basic hypothesis is that personal attitudes towards mental illness are a major determinant of reaction to community mental health facilities. Unfortunately, if communities continue to demonstrate rejecting attitudes, the potential therapeutic value of a mental health facility as being "community-based" could be at stake.

The following chapter is a review of some of the literature that has been written on attitudes towards mental health facilities. Since the community plays a vital role in the success or failure of a facility, it will be determined which attitudes characterize accepting and rejecting neighbourhoods. This will aid planners in locating mental health facilities in neighbourhoods where public opposition and patient dissatisfaction are potentially less.

2.2 HISTORY

Prior to deinstitutionalization, Canadian mental health facilities were generally large, segregated and isolated from population centres. Institutions were located in small towns, rural areas or distant suburbs because these tranquil settings were thought to be most therapeutic. Most frequently, the asylum was in the country, not too far from an urban centre, with a pleasant view and sufficient grounds for work and recreation. It was thought that if mental illness was induced by conditions of society, then mental health could be treated by removal of the

patients from the source of irritation. Therefore, the original intent of mental health facilities was to provide a protective setting for the mentally ill that would also offer treatment. However, the actual consequences, until recent years have been the creation of "human warehouses" that dehumanized, and depersonalized patients rather than treat and rehabilitate them (Klerman, 1977, pg. 620). For example, there have been many negative consequences of institutional-based care. There are reports which indicate accounts of breakdown of sociability, apathy, loss of individuality, deterioration of personal care habits, resignation, dependency, loss of contact with relatives, stigmatization, routinization, and high rates of recidivism. Generally, these effects were caused by failure on the part of the institutions to provide remediation and development of functional and social skills required for integration into the community (Canadian Training Institute, 1984, pg.2).

2.3 DEINSTITUTIONALIZATION

During the last twenty-five years, the improvement and effectiveness of psychotropic drugs in eliminating the positive symptoms of psychosis, has contributed to the adoption of a new policy of reducing the length of psychiatric hospitalizations, causing a shift away from the use of (traditional security oriented) institutions for the treatment of the mentally ill to community-based institutions (Hodgins, 1987, pg. 7). The shift has been away from large, often isolated, institutions and toward community residential facilities such as small group homes, halfway houses and independent living arrangements. These homes have become

an essential component of the rehabilitation system, particularly for people making the transition to independent living (Canadian Training Institute, 1984, pg. 2).

Therefore, motives for a move away from institution-based treatment have been therapeutic, based on the view that the well-being of patients is best served by their being part of a normal environment, but also economic, based on the desire to achieve reductions in the costs of providing care. The aim of this type of community residential facility is to assist people who have been previously isolated to acquire the attitudes and skills necessary to live in a "normal" community as contributing and self-reliant citizens.

Since deinstitutionalization, the discharged population has gravitated toward specific zones in our urban areas. These have typically been core areas of the inner city where the service-dependent have found helping agencies and cheap housing opportunities. Studies of service-dependent populations have illustrated a common pattern of "ghettoization" of client and facilities in such cities as Toronto. The inner city has become a coping mechanism where ex-patients find help in search for homes, and jobs and can locate other support facilities, begin or renew friendships or start self-help groups. Therefore, here in an "asylum without walls" the service-dependent are able to link up with a social network that provides friendship, guidance and support.

Unfortunately, the mentally ill occupy the worst area in the inner city. Since they share their space with discharged prisoners, drug addicts and prostitutes, they are terrorized, victimized and physically abused. Moreover, recently, the pressures to gentrify and redevelop the urban zone of dependence has begun to push

mentally-ill ex-patients and other service-dependent residents and their support facilities out of the inner city. Therefore, because of much public opposition in the suburbs, and lack of cheap housing, many mental health patients are left homeless.

Even if mental health patients are able to follow facilities and move out of the inner city, then other implications arise, specifically, the dismantling of the ghetto, which some regard as a supportive environment, not easily reproduced once the mentally ill are more widely distributed throughout the city (Klerman, 1977, pg.623). However, this is not always the case. The majority of ex-mental health patients live far from facilities and support groups. Unfortunately, limited ability for social interaction means they often wonder the streets or sit aimlessly looking at television. Hence, unintentional consequences of deinstitutionalization may be new forms of anomie and isolation for the chronic and dependent ex-patients, who are "in" but not "of" the community (Klerman, 1977, pg. 629).

It is important to note that mental health patients have constantly been segregated over time and over space. Whether in the suburbs or in the city, mental health patients have never been treated as part of a community. It seems that it is only an illusion that mental health patients who are placed in mental health facilities are in the community (Lamb and Goertzel, 1971, pg. 31). Some experts have acknowledged that community care is an ideal that may never be fully realized in practice.

Ex-psychiatric patients are not considered desirable tenants or neighbours. Instead, they are intensely stigmatized in communities that often fight hard to keep

psychiatric patients out of their neighbourhoods. The phenomenon is called "Not in My Back Yard," or NIMBY, for short (Cole, 1988, pg. 10). Therefore, the trend toward community residential alternatives has been met with strong community opposition. Recent experience has indicated that the introduction of such a centre into a community is fraught with difficulties, outright public hostility and rejection. This opposition is based on fears of a decline in personal safety and security of property. Additionally, individual community members are often fearful that the resale value of residential real estate will decrease (Canadian Training Institute, 1984, pg. vi).

Such facts contribute to the mounting evidence of reinstitutionalizing the ex-patients permanently because they are worse off than ever before. For example, the lack of community services has been cited as the major cause of the "revolving door syndrome" which indicates that the rehospitalization rate is high for those who are not followed-up in the community. Consequently, it seems clear that there is a need for community resources in order to reduce the readmission rate (Hodgins, 1987, pg. 8). Community-based services have been established to reduce rehospitalization and improve psychosocial functioning, but their existence has not solved the problem. One study indicated that less than two-thirds of patients referred to community-based resources followed through with the initial contact, and of the patients who did, 50 percent terminated their contact before services were provided to their completion (Krupa et al., 1988, pg. 14). In contrast, if they were on the grounds of a state hospital, mental health patients would have access to various recreational facilities and group activities.

Evidently, the problem of deinstitutionalization has in part to do with the neighbourhood in which a mental health facility is located and the public reactions to the mentally ill in the neighbourhood. Unfortunately, the potential therapeutic value of community mental health care could be at stake if residents continue to demonstrate rejecting attitudes towards facilities.

2.4 CHARACTERISTICS OF ACCEPTING AND REJECTING NEIGHBOURHOODS

The reaction of local residents is crucial to the success of community care because rejection of the mentally ill is likely to undermine the therapeutic effect of being part of a "normal environment." For example, if there is community opposition, then increased contact between the mentally ill and the community may engender friction in neighbourhoods, to the extent that "... if the force of public attitudes is not taken into account, the eventual outcome may be the exacerbation of public fears accompanied by a retreat to custodial care and removal from the community" (Dear and Taylor, 1982, pg.2). Therefore, attitudes of residents in neighbourhoods where community based care facilities are located are of primary importance in determining their social integration in the community.

Taylor et al. (1984) describe a model that predicts aggregate neighbourhood responses to facilities in Toronto in terms of ecological, demographic, and socioeconomic variables. This paper is helpful in developing profiles of the social and physical characteristics of accepting and rejecting communities. Moreover,

these profiles of accepting and rejecting communities will aid planners in locating mental health facilities in locations where public opposition and patient dissatisfaction are potentially less.

The model was expressed as a simple equation incorporating six major dimensions of neighbourhood structure as independent variables that previous analyses indicated are important for predicting aggregate response to facilities. Community response is some function of: land use mix, socioeconomic status, demographic structure, community homogeneity, community stability, and population density.

Survey respondents rated the desirability of having a mental health facility located within three different distances of their homes: 7-12 blocks; 2-6 blocks; and 1 block. Ratings were made on a 9-point scale ranging from "extremely desirable" (score=1) to "extremely undesirable" (score=9). The degree of opposition to mental health facilities is most predictable on the basis of neighbourhood characteristics when the proposed location is within one block of the place of residence (Taylor et al., 1984, pg. 40).

Multiple regression analysis was the primary basis for testing the model. The results of the regression analysis allowed the construction of general profiles of the characteristics of accepting and rejecting neighbourhoods. Accepting neighbourhoods are characterized as having relatively transient populations, high population density, mixed housing stock, few family-based households and lower income. Rejecting neighbourhoods are characterized as having stable populations, low population density, predominantly single-family housing, a high proportion of

families (and children), and higher income levels. In many respects, these distinctions correspond with the differences between the central city and the suburbs (Taylor et al., 1984, pg. 43). A map which was constructed to show the spatial distribution of the neighbourhood groups revealed a clear spatial pattern with a marked distance-decay in facility desirability away from the centre of the city. Consistent with common belief, suburban neighbourhoods exhibit more negative attitudes towards mental health facilities.

The results of the regression analysis strongly confirm the findings of Trute and Segal (1976). Their studies focused on the social integration of mental health facilities in residential communities, and identified factors associated with varying levels of integration. Particularly, the study explored whether differences in social-environmental characteristics influenced levels of social integration based on data from California and Saskatchewan. Facilities with the highest levels of integration were in neighbourhoods having low social cohesion. These were characterized by a low proportions of married couples, high rates of single parent families, and never married and divorced individuals. There was a low proportion of middle-aged individuals and many older persons; income levels were low and there were many rented dwellings suggestive of transience. Also, these neighbourhoods would most likely be those marked with disruption and deviance. These locales are high in crime rates, delinquency, drug consumption, and suicide. Many "slum areas" and "skid rows" would correspond to such a neighbourhood setting. On the other hand, social integration was low in highly cohesive neighbourhoods, particularly suburban areas with nuclear families and homogeneity in terms of race,

class and educational background. Also, individuals living in these areas would more frequently participate in community clubs and civic organizations, and would maintain regular religious affiliation. Such neighbourhoods tended to "close ranks" against the invasion of the mentally ill (Taylor et al., 1979, pg. 282).

In addition, the findings of Linsky (1970) also confirmed the findings of Trute and Segal. This study tested three hypotheses concerning types of individuals who are likely to be excluded from a community for mental illness. The patient sample consisted of 14,304 first admissions to three State Mental Hospitals in Washington State, for the period 1957-1964. The results concluded that those who lack close social ties in the community are more likely to be excluded than those with such ties with the community. For example, persons who lived alone or with non-relatives had higher exclusion rates than persons living with their own families. The non-married are more likely to be excluded than the married, and persons not in the labor force are more likely to be excluded than those in the labor force (Linsky, 1970, pg. 160).

The main point that must be emphasized is the consistency of the results from these various studies. The characteristics of accepting and rejecting neighbourhoods are similar regardless of the study location.

This research paper provides a further examination of neighbourhood differences in reactions to community mental health facilities using data for three cities derived from a study conducted by the Canadian Training Institute (1984). Specific attention will be paid to the relationships between the socio-demographic characteristics of neighbourhoods and perceptions of facility impacts and ratings

of facility desirability.

CHAPTER 3

RESEARCH DESIGN

3.1 INTRODUCTION

The following chapter describes the research design, the data source and the methods of analysis for this research paper. Statistical analyses are conducted in order to test the hypothesis that attitudes toward mental health facilities vary spatially between different types of neighbourhoods.

3.2 DATA SOURCE

The study conducted by the Canadian Training Institute (CTI) at York University in Ontario provides relevant data on attitudes towards mental health facilities for this research paper. The research hypothesis is that personal attitudes towards mental health are a major determinant of reactions to community mental health facilities. Statistical analyses of the attitude survey data are conducted to determine neighbourhood variations in facility acceptance.

The CTI data include information on individual attitudes collected from telephone interviews using a prescribed questionnaire. The information was collected from individuals resident in experimental and control neighbourhoods in three Ontario cities: Toronto, Ottawa, and London. The households to be called and interviewed were selected at random from a master list.

The questionnaire included a variety of questions dealing with both mental health group homes and correctional group homes. However, the questions used in this analysis deal specifically with mental health group home (Appendix). Statistical analyses are conducted to test people's attitudes toward locating mental

health facilities in their neighbourhood. Additional analyses are conducted to test the desirability of having a mental health facility located at different distances from the respondents home.

3.3 STATISTICAL METHODS

The statistical tests were conducted using SAS, a sophisticated software system for data analysis. The first step in the analysis was to obtain frequency distributions for the relevant variables. These frequency tables were the basis for describing the distributions of accepting and rejecting attitudes toward mental health facilities.

Cross-tabulations were used to show the joint distribution of two or more variables. For example, the socio-demographic characteristics of the survey respondents were cross-tabulated with attitudinal variables. This is useful in knowing the characteristics of neighbourhood groups which either oppose or support the idea of a mental health group home located in their neighbourhood. In addition, this information can also provide a profile of neighbourhoods which might guide the delivery of educational programs to promote acceptance of mental health group homes.

The individuals responding to the questionnaire expressed their attitudes on both nominal scales and ordinal scales. A nominal scale is a series of quantitative classes of grouped individual responses to a particular question, characterized by a distinguishing number (Hays, 1981, pg. 60). On the other hand, ordinal scales

of measurement are classes of responses which are ranked or ordered in a specific manner (Taylor, 1977, pg. 40). There were two sets of ordinal scales used in the survey; a six point ordinal scale to measure facility impact and a eight point ordinal scale to measure facility desirability.

The NPAR1WAY Procedure is a procedure used to perform analysis of variance on ranks and certain rank scores of a response variable across a one-way classification. It is a nonparametric procedure that is used to test hypotheses under small-sample conditions such as an attitude survey.

The nonparametric test that was used for this analysis was the Kruskal-Wallis test. This procedure was used to test the hypothesis that attitudes towards mental health group homes vary spatially between different types of neighbourhoods. In order to test this hypothesis two sets of relationships were tested; the relationship between facility impact and neighbourhoods; and the relationship between facility desirability and neighbourhoods.

CHAPTER 4

ANALYSIS AND RESULTS

4.1 INTRODUCTION

A number of statistical analyses were performed on the attitude survey data collected by the Canadian Training Institute. Only a limited number of questions were included in the analyses which dealt specifically with mental health group homes.

The results are presented in four sections. In the first section, the characteristics of the samples in each of the nine neighbourhoods are described. These data provide a basic profile of the socioeconomic (education, tenure and income) and demographic (age and sex) characteristics of the sample population. In the second section, general attitudes to mental health facilities by the nine neighbourhoods are described. This data provides a level of support and opposition for each neighbourhood. In the third section, perceived impacts of mental health facilities by the nine neighbourhoods are described. Specifically, perceived impacts on property values, movement into the neighbourhood, visual appearance, and children's safety are discussed. In the final section, ratings of facility desirability at three distances from the respondent's home: 7-12 blocks, 2-6 blocks, and within 1 block, are described.

4.2 NEIGHBOURHOOD CHARACTERISTICS

In this section, the respondents were asked some basic information which helped in constructing the neighbourhood characteristics table (Table 4.1). The socio-demographic characteristics of each neighbourhood shows a high significant

difference between each neighbourhood in the study. It is important to examine the neighbourhood composition in order to determine whether the different types of neighbourhood are the cause of different attitudes expressed by the respondents.

The educational data is summarized as the percentage of the respondents with some university training or college level of education. The percentages range from a low of 7.98 (Neighbourhood 3) to a high of 36.94 (Neighbourhood 6). The statistical test result (chi square= 170.35; $p < 0.0001$) indicates a highly significant difference in education levels across neighbourhoods. This finding is important in light of previous studies of attitudes towards mental health facilities which show greater opposition in areas of higher education.

The tenure characteristics are reported as the percentage of owners in each neighbourhood . The percentages range from a low of 23.94 (Neighbourhood 4) to a high of 72.87 (Neighbourhood 8). The statistical test result (chi square= 195.26; $p < 0.0001$) indicates a highly significant difference in tenure status across neighbourhoods. This finding is important in light of previous studies of attitudes towards mental health facilities which show greater opposition in areas with a higher percentage of home-owners. Home-owners have a greater "stake" in their environment and will therefore, resist perceived impacts to the quality of their neighbourhood.

The age group data is summarized as the percentage of respondents between the ages of 24-40. The percentages range from a low of 31.40 (Neighbourhood 9) to a high of 63.58 (Neighbourhood 6). The statistical result (chi

square= 41.75; $p < 0.0001$) indicates a highly significant difference in age levels across neighbourhoods. This finding is important in light of previous studies of attitudes towards mental health facilities which show greater opposition in areas with a greater percentage of people in this age group. This age group is characterized as being more community oriented because the individuals belonging to this age group are more inclined to be married and raising young school aged children. Also, depending on the age of their children, these individuals will either accept or reject a mental health group home in their neighbourhood.

The household income data is summarized as the percentage of respondents with greater than $25,000 before taxes. The percentages range from a low of 28.35 (Neighbourhood 9) to a high of 71.14 (Neighbourhood 1). The statistical test result (chi square= 140.82; $p < 0.0001$) indicates a highly significant difference in income levels across neighbourhoods. This finding is important in light of previous studies of attitudes towards mental health facilities which show greater opposition in areas of higher income levels. Households with income greater than $25,000 would most likely represent households where more than one adult is working. Because these households tend to be located in better neighbourhoods, residents fear that their property value or quality of their neighbourhood would decrease.

The sex data is summarized as the percentage of respondents which are female. The percentages range from a low of 47.31 (Neighbourhood 3) to a high of 62.23 (Neighbourhood 8). The statistical test result (chi square= 11.62; $p < 0.1691$) indicates no significant differences across neighbourhoods. This finding is important in light of previous studies of attitudes towards mental health facilities

which show greater acceptance in areas with a higher percentage of females. The high rate of responses, and particularly neutral responses, among females can possibly be explained by the time of day the telephone interviews were conducted. For instance, there is a greater likelihood of finding females at home during daytime hours than males.

In light of previous studies, neighbourhood differences can be related back to socio-demographic differences and differences in attitudes towards mental health facilities. Most of the respondents in the neighbourhoods that have lower levels of education also rent their dwellings and make less than $24,999 annually. Although no inference can be made directly, these socioeconomic characteristics suggest this neighbourhood type would be more tolerant towards mental health group homes. Similarly, the respondents in the neighbourhoods that have higher levels of education also own their dwellings and make more than $25,000 annually. Again, these socioeconomic characteristics suggest this neighbourhood type would be less tolerant towards mental health group homes. Unfortunately, not all of the neighbourhoods show such a clear correspondence between characteristics of neighbourhoods and attitudes recorded.

4.3 GENERAL ATTITUDES TOWARDS MENTAL HEALTH FACILITIES

In this section, the respondents were asked how they felt about having a mental health group home located in their neighbourhood. The data is summarized as the percentage of the respondents which support and oppose a

mental health group home in their neighbourhood (Table 4.2). The percentages vary from a low of 60.00 (Neighbourhood 2) to a high of 100.00 (Neighbourhoods 6 and 7). For example, the majority of the respondents in Neighbourhood 7 "strongly favoured" having a mental health group home in their neighbourhood. In general, this corresponds to a high level of support towards mental health group homes among all neighbourhoods. In principle, the statistical test result (chi square=36.00; $p<0.0001$) indicates a highly significant difference in levels of support across neighbourhoods. This finding is important in light of previous studies of attitudes towards mental health facilities which show greater opposition in areas of lower levels of support.

4.4 PERCEIVED IMPACTS OF MENTAL HEALTH FACILITIES

In this section, the results relative to perceived impacts of mental health facilities are described (Table, 4.3). Specifically, perceived impacts on property values, movement into the neighbourhood, visual appearance, and children's safety will be discussed. The results are summarized in a table under the headings: % positive (+), % neutral (N), and % negative (-) reactions. The reactions will be described in turn.

Table 4.1

NEIGHBOURHOOD CHARACTERISTICS

NEIGHBOUR-HOODS	EDUCATION SOME UNIV/COLL %	TENURE OWN %	AGE 26-40 %	INCOME > $25,000 %	SEX FEMALE %
1	27.27	64.50	40.10	71.14	55.72
2	14.38	65.00	44.70	60.49	53.46
3	7.98	68.64	35.25	55.29	47.31
4	33.33	23.94	57.59	62.96	52.17
5	14.81	56.03	38.35	50.19	59.38
6	36.94	29.94	63.58	67.28	54.72
7	31.48	58.33	54.43	63.95	59.17
8	18.28	72.87	37.11	42.86	62.23
9	18.09	30.41	31.40	28.35	56.77
CHI SQUARE =	170.35	195.26	41.75	140.82	11.62
DF =	8	8	8	8	8
SIGNIFICANCE =	0.0001	0.0001	0.0001	0.0001	0.1691

Table 4.2

GENERAL ATTITUDES TO MENTAL HEALTH FACILITIES BY NEIGHBOURHOOD

NEIGHBOURHOODS	GENERAL ATTITUDES	
	SUPPORT %	OPPOSE %
1	83.33	16.67
2	60.00	40.00
3	70.00	30.00
4	88.89	11.11
5	95.46	4.54
6	100.00	0.00
7	100.00	0.00
8	66.67	33.33
9	80.00	20.00

CHI SQUARE = 36.99   DF = 8   SIGNIFICANCE = 0.0001

4.4.1 ATTITUDES TOWARDS PROPERTY VALUES

The results indicate that the majority of the respondents reported either neutral or negative attitudes to perceived impacts on property values. Considering the neutral responses, the percentages range from a low of 34.39 (Neighbourhood 1) to a high of 66.67 (Neighbourhood 8). Surprisingly, in seven out of the nine neighbourhoods the majority responded that property values would "stay the same". Considering the negative responses, the percentages range from a low of 31.51 (Neighbourhood 8) to a high of 62.44 (Neighbourhood 1). For example, in Neighbourhoods 1 and 3, the majority reported that mental health group homes would "somewhat decrease" property value. The statistical test result (chi square = 54.20; $p < 0.0001$) also indicates a highly significant difference in attitudes towards property values. This finding is important in light of previous studies of attitudes towards mental health facilities which show greater opposition in areas with a prevalence of negative attitudes towards perceived impacts on property values.

4.4.2 ATTITUDES TOWARDS MOVEMENT INTO THE NEIGHBOURHOOD

The results indicate that the majority of the respondents reported negative attitudes to perceived impacts on movement into a neighbourhood in which a mental health group home is located. For example, in seven out of the nine neighbourhoods, the majority reported that a mental health group home would "somewhat discourage" people from moving into their neighbourhood. The percentages vary from a low of 44.10 (Neighbourhood 9) to a high of 64.28

(Neighbourhood 3). On the positive side, in two neighbourhoods (6 and 9), more respondents reported neutral than negative attitudes. Considering the neutral responses, the percentages vary from a low of 33.77 (Neighbourhood 3) to a high of 50.00 (Neighbourhood 6). The statistical test result (chi square= 34.65; $p < 0.0001$) also indicates a highly significant difference in attitudes towards movement into a neighbourhood in which a mental health group home is located. This finding is important in light of previous studies on attitudes towards mental health facilities which show greater opposition in areas with a prevalence of negative attitudes towards movement into the neighbourhood.

4.4.3 ATTITUDES TOWARDS THE VISUAL APPEARANCE

The results indicate that the majority of the respondents reported neutral attitudes to perceived impacts on the visual appearance of a mental health group home. For example, in eight out of the nine neighbourhoods studied, the highest percentages were in the "have no effect on" category. The percentages range from a low of 49.19 (Neighbourhood 3) to a high of 64.84 (Neighbourhood 1). On the positive side, less respondents reported a negative response than a positive response. For instance, the majority of the respondents in Neighbourhood 5 believed the visual appearance of a mental health group home would be maintained "somewhat better" than other houses in the neighbourhood. The statistical test result (chi square= 94.17; $p < 0.0001$) also indicates a highly significant difference in attitudes towards the visual appearance of a mental health

group home. This finding is important in light of previous studies of attitudes towards mental health facilities which show greater acceptance in areas with a prevalence of positive attitudes towards the visual appearance of a mental health facility.

4.4.4 ATTITUDES TOWARDS CHILDREN'S SAFETY

The results indicate that the majority of the respondents reported neutral attitudes to perceived impacts on children's safety in a neighbourhood in which a mental health group home was located. The percentages range from a low of 50.77 (Neighbourhood 3) to a high of 79.41 (Neighbourhood 9). On the negative side, more respondents expressed a negative response than a positive response. The percentages range from a low of 13.51 (Neighbourhood 9) to a high of 49.32 (Neighbourhood 3). The statistical test result (chi square = 65.82; $p < 0.0001$) also indicates a highly significant difference in levels of attitudes towards children's safety. This finding is important in light of previous studies of attitudes towards mental health facilities which show greater opposition in areas with a prevalence of negative attitudes towards children's safety.

Table 4.3
PERCEIVED IMPACTS OF MENTAL HEALTH FACILITIES

	PERCEIVED IMPACTS											
NEIGHBOURHOODS	PROPERTY VALUES			MOVES			V. APPEARANCE			SAFETY		
	%+	%N	%-	%+	%N	%-	%+	%N	%-	%+	%N	%-
1	3.17	34.39	62.44	3.70	36.51	59.78	24.73	64.84	10.44	8.20	57.38	34.42
2	0.73	50.36	48.91	0.00	35.92	64.08	26.49	64.10	9.40	3.97	59.52	36.50
3	1.32	46.05	52.63	1.95	33.77	64.28	36.29	49.19	14.52	0.00	50.77	49.23
4	0.00	50.61	49.39	1.20	39.16	59.64	28.67	56.64	14.69	4.03	69.13	26.85
5	4.00	52.00	44.00	2.42	41.55	56.04	52.57	43.16	4.27	12.98	68.27	18.75
6	2.34	65.63	32.03	4.05	50.00	45.94	18.31	56.34	25.35	7.14	61.43	31.43
7	2.52	59.12	38.36	4.40	43.40	52.20	15.48	61.94	22.53	5.77	53.85	40.39
8	1.82	66.67	31.51	1.82	43.03	55.15	44.51	49.68	5.81	12.88	72.39	14.72
9	1.84	64.42	33.74	4.35	51.55	44.10	35.58	60.74	3.68	7.06	79.41	13.53
CHI SQUARE =	54.20			34.65			94.17			65.81		
DF =	8			8			8			8		
SIGNIFICANCE =	0.0001			0.0001			0.0001			0.0001		

4.5 RATINGS OF FACILITY DESIRABILITY

In this section, respondents were asked to rate the desirability of having a mental health group home located at three distances from the respondent's home: 7-12 blocks, 2-6 blocks, and within 1 block (Table 4.4). The results are summarized in a table under the headings: % positive (+), % neutral (N), and % negative (-) reactions. The reactions will be described in terms of desirability, in turn.

4.5.1 LOCATIONAL PREFERENCE: 7-12 BLOCKS

The results indicate that the majority of the respondents rated the desirability of having a mental health group home located 7-12 blocks from the respondent's home as neutral. The percentages range from a low of 46.70 (Neighbourhood 1) to a high of 82.54 (Neighbourhood 9). On the positive side, the majority of the respondents rated the desirability of having a mental health group home located 7-12 blocks more "desirable" than "undesirable" in all nine neighbourhoods. The statistical test result (chi square= 32.22; $p < 0.0001$) indicates a highly significant difference in the rate of desirability across neighbourhoods. This finding is important in light of previous studies of attitudes towards facility desirability which show greater acceptance in areas located farther away from a mental health facility.

4.5.2 LOCATIONAL PREFERENCE: 6-12 BLOCKS

Similarly, the results indicate that the majority of the respondents rated the desirability of having a mental health group home located 2-6 blocks from the respondent's home as neutral. The percentages range from a low of 41.75 (Neighbourhood 1) to a high of 67.97 (Neighbourhood 6). On the negative side, the majority of the respondents in Neighbourhood 3 rated the desirability of having a mental health group home located 2-6 blocks more "undesirable" than "desirable". The statistical test result (chi square= 28.20; $p < 0.0001$) indicates a highly significant difference in the rate of desirability across neighbourhoods. This finding is important in light of previous studies on attitudes towards facility desirability which show greater opposition in areas with a prevalence of negative attitudes.

4.5.3 LOCATIONAL PREFERENCE: WITHIN 1 BLOCK

Again, the results indicated that the majority of the respondents rated the desirability of having a mental health group home located within 1 block from the respondent's home as neutral. The percentages range from a low of 40.41 (Neighbourhood 1) to a high of 64.75 (Neighbourhood 6). The statistical test result (chi square= 28.58; $p < 0.0001$) indicates a highly significant difference in the rate of desirability across neighbourhoods. For example, the majority of the respondents in five neighbourhoods (Neighbourhoods 1, 3, 6, 7, and 8) rated a mental health group home located within 1 block as "undesirable" than "desirable"

In addition, the majority of the respondents in two neighbourhoods (Neighbourhoods 4 and 8) rated a mental health group home located within 1 block "desirable" than "undesirable". This finding is important in light of previous studies on attitudes towards facility desirability which show greater opposition in areas located closer and especially within 1 block from a mental health facility.

In every neighbourhood, the negative attitudes increased from 7-12 blocks to within 1 block. This corresponds to previous studies which show that respondents rate a mental health facility less "desirable" if it is located closer to their neighbourhood. Therefore, there exists a distance decay in facility desirability away from a mental health group home. For example, the majority of the respondents in Neighbourhood 3 rated the facility more "undesirable" as distance decreased between the respondent and the group home; 7-12 blocks= 11.37%, 2-6 blocks= 23.31%, and within 1 block= 35.15%.

4.6 CONCLUSIONS

By analyzing the basic characteristics of the respondents in terms of education, tenure status, income, age and sex, a socio-demographic profile was constructed. The value of this information is that it allowed for comparisons and associations to be made between significant attitudes and socio-demographic characteristics.

Although no inference can be made directly, a prevalence of negative attitudes by Neighbourhoods 1, 2, 7, and 8, suggests these neighbourhoods would

likely reject a mental health group home in their neighbourhood. These neighbourhoods possess many of the qualities of rejecting neighbourhoods. For example, the majority of the respondents exhibit socio-demographic characteristics and negative attitudes towards facility impacts and facility desirability characterized by rejecting neighbourhoods. On the other hand, the opposite is evident of accepting neighbourhoods. The prevalence of positive attitudes by Neighbourhoods 4, 5, 6, and 9, suggests these neighbourhoods would likely accept a mental health group home in their neighbourhood. These neighbourhoods likewise exhibit socio-demographic characteristics and positive attitudes towards facility impacts and facility desirability characterized by accepting neighbourhoods.

Table 4.4
RATINGS OF FACILITY DESIRABILITY

DESIRABILITY RATINGS: LOCATIONAL PREFERENCE

NEIGHBOURHOODS	7-12 BLOCKS			2-6 BLOCKS			< 1 BLOCK		
	%+	%N	%-	%+	%N	%-	%+	%N	%-
1	36.04	46.70	17.26	32.92	41.75	27.32	24.87	40.41	34.72
2	40.53	49.67	9.80	33.12	51.95	14.94	22.87	54.90	22.22
3	16.76	71.86	11.37	14.10	62.58	23.31	10.30	54.55	35.15
4	32.09	59.89	8.02	27.96	60.22	11.83	22.70	55.68	21.26
5	34.51	56.08	9.41	43.78	52.70	15.35	27.30	49.40	23.30
6	36.42	68.55	5.03	19.61	67.97	12.42	15.83	64.75	19.43
7	18.68	77.11	4.21	16.86	67.47	15.66	16.26	56.88	26.89
8	14.51	81.18	4.30	13.66	72.68	13.66	11.60	64.64	23.75
9	13.75	82.54	3.71	14.52	78.49	6.99	14.21	71.58	14.21
CHI SQUARE =	32.22			28.20			28.58		
DF =	8			8			8		
SIGNIFICANCE =	0.0001			0.0004			0.0004		

CHAPTER 5

CONCLUSIONS

5.1 SUMMARY

In summary, the analysis and results lead to the following conclusions. The research hypothesis was confirmed. The effects of neighbourhood factors do influence attitudes towards mental health facilities. The results correspond to other studies in terms of socio-demographic profiles and characteristics of accepting and rejecting neighbourhoods regardless of the study location.

A high level of negative attitudes towards facility impact and facility desirability were expressed by Neighbourhoods 1, 2, 3, 7, and 8. This suggests that these neighbourhoods would potentially reject a mental health group home in their neighbourhood. The majority of the respondents in these neighbourhoods exhibited socioeconomic characteristics such as higher education levels, higher home-ownership levels, and higher income levels, characteristic of rejecting neighbourhoods. The opposite is evident for the accepting neighbourhoods. A high level of positive attitudes towards facility impact and facility desirability were expressed by Neighbourhoods 4, 5, 6, and 9. This suggests that these neighbourhoods would potentially accept a mental health group home in their neighbourhood. The majority of the respondents in these neighbourhoods exhibited socioeconomic characteristics such as lower education levels, lower home-ownership levels, and lower income levels, characteristic of accepting neighbourhoods.

5.2 NEW FINDINGS

With reference to the statistical analyses, it is evident that a large percentage of the population responded "neutrally" towards facility impact and facility desirability. This is impressive because it means that people's attitudes are slowly changing for the better. The "older population" is an exception. The majority exhibit negative attitudes towards mental health facilities. Therefore, it is important to concentrate on enhancing the educational programs for this population in order to get them more accepting.

The social organization of a city has changed over time causing people of particular socioeconomic classes not to locate in traditional distinct neighbourhoods. Gentrification and urban renewal has introduced the "yuppie population", young urban professionals, into the inner city. Therefore, the inner city is no longer concentrated with a transient population but rather a mixture of all socioeconomic classes. Hence, the result is, eventually all socioeconomic classes will be forced to come into contact with mental health facilities. Hopefully, negative attitudes toward mental health facilities will eventually be minimized with an increase of interaction between the community and the ex-psychiatric patients.

5.3 PLANNING IMPLICATION

The characteristics of accepting and rejecting neighbourhoods can help planners develop guidelines for locating mental health facilities in locations where public opposition and patient dissatisfaction are potentially less.

Results on neighbourhood differences in reaction to mental health facilities have important implication in types of implementation strategies that would be more appropriate for different types of neighbourhoods. A high profile approach may be more appropriate in areas where high levels of opposition are anticipated. Whereas, a low profile approach may be more appropriate in areas where low levels of opposition are anticipated.

However, further planning implications have to be addressed. Mainly, the problem of negative attitudes towards mental illness in general. The needs of ex-psychiatric patients must be publicized in order to promote acceptance of mental health facilities. It is obvious that much needs to be done in terms of educating society.

If communities are to become more tolerant of mental health facilities, individuals must be presented with factual current information from which they can learn about mental illness. Also, promotional approaches should be considered for mental illness on all available media such as television and radio. In addition, a number of public education programs must be designed to foster more positive attitudes in school and in different neighbourhoods. Evidently, structured attempts to increase public awareness can do much to alter individual attitudes and change misconceptions.

APPENDIX

APPENDIX

The following questions are extracted from the Canadian Training Institute questionnaire on attitudes to community-based facilities. Only questions that dealt with mental health group homes were used for statistical analysis.

CANADIAN TRAINING INSTITUTE
OCTOBER 1983
YORK UNIVERSITY

ATTITUDES TO COMMUNITY-BASED FACILITIES

Good __________ My name is __________ and I am with the Canadian Training Institute at York University. We're conducting a survey on attitudes to community-based facilities in your area. We would like to know your feelings about various community services.

ATTITUDES TO MENTAL HEALTH FACILITIES

1. How do you feel about having the mental health group home in your neighbourhood? Would you say you strongly favour, somewhat favour, somewhat oppose, or strongly oppose?

Strongly favour ----- 1
Somewhat favour ---------- 2
Somewhat oppose --------------- 3
Strongly oppose ------------------- 4
Don't know ----------------------------- 9

2. Thinking of property values, how do you feel the presence of a mental health group home would affect property values in your neighbourhood? Would they greatly increase, somewhat increase, somewhat decrease, or greatly decrease?

Greatly increase ----- 1
Somewhat increase ---------- 2
Stay the same ------------------ 3
Somewhat decrease -------------------- 4
Greatly decrease -------------------------- 5
Don't know ------------------------------------- 9

3. Thinking of movement into your neighbourhood if a mental health group home were to be established would you say it would greatly encourage, somewhat encourage, somewhat discourage, or greatly discourage people from moving into your neighbourhood?

Greatly encourage ----- 1
Somewhat encourage ---------- 2
Have no effect on ---------------- 3
Somewhat discourage -------------------- 4
Greatly discourage -------------------------- 5
Don't know -- 9

4. Thinking of the visual appearance of a mental health group home would you say it would be maintained much better, somewhat better, somewhat worse, or much worse than other houses in the neighbourhood?

Much better ----- 1
Somewhat Better ------- 2
Have no effect on ---------- 3
Somewhat worse ------------------- 4
Much worse ---------------------------- 5
Don't know ---------------------------------- 9

5. Thinking of children's safety would you say a mental health group home in your neighbourhood would greatly increase, somewhat increase, somewhat decrease, or greatly decrease children's safety?

Greatly increase ----- 1
Somewhat increase ---------- 2
Have no effect on --------------- 3
Somewhat decrease -------------------- 4
Greatly decrease --------------------------- 5
Don't know -- 9

6. How would you rate the desirability of having a mental health group home located 7-12 blocks from your home? Would you rate it:

Extremely desirable ----- 1
Moderately desirable ---------- 2
Slightly desirable ---------------- 3
Neutral -------------------------------- 4
Slightly undesirable ------------------------- 5
Moderately undesirable ----------------------------- 6
Extremely undesirable ------------------------------------ 7
Don't know -- 9

7. How would you rate the desirability of having a mental health group home located 2-6 blocks from your home? Would you rate it:

Extremely desirable ----- 1
Moderately desirable ---------- 2
Slightly desirable ---------------- 3
Neutral -------------------------------- 4
Slightly undesirable ------------------------- 5
Moderately undesirable ----------------------------- 6
Extremely undesirable ------------------------------------ 7
Don't know -- 9

8. How would you rate the desirability of having a mental health group home located 1 block from your home? Would you rate it:

Extremely desirable ----- 1
Moderately desirable ---------- 2
Sightly desirable ------------------- 3
Neutral ----------------------------------- 4
Slightly undesirable --------------------------- 5
Moderately undesirable ------------------------------- 6
Extremely undesirable -------------------------------------- 7
Don't know --- 9

BASIC DATA

9. Can you tell me the highest level of education your have completed?

Some Public School ----- 1
Public School Graduation ----- 2
Some High School ------------------ 3
High School Graduation ------------------ 4
Technical Training Beyond Secondary School ----- 5
Some University or College -------------------------- 6
University or College Graduation -------------------------- 7
Post Graduate Work -- 8

10. Do you own or rent your residence?

Rent ---------- 1
Own ----------- 2
Other --------- 3

11. Would you please tell me your age?

12. Can you please tell me which range most closely describes the income before taxes of this household in the past year?

Less than $10,000 ----- 1
$10,000 to $14,999 ---------- 2
$15,000 to $19,999 ---------------- 3
$20,000 to $24,999 ---------------------- 4
$25,000 to $29,999 ---------------------------- 5
$30,000 to $35,000 --------------------------------- 6
More than $35,000 -- 7
Refused -- 8
Don't know ---9

13. Sex of Respondent:

Male ------------ 1
Female ---------- 2

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