THE CONCEPT OF FIT AND PUBLIC RESPONSE TO COMMUNITY MENTAL HEALTH FACILITIES

by

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ABSTRACT:

The focus of this thesis is on public response to community mental health facilities. The mentally ill are increasingly being moved out of the asylum and into small group homes and treatment facilities in the community. The response of community residents to this move, as far as it is understood, is generally one of opposition and rejection. Further understanding of response to community mental health facilities, with a view to predicting and improving that response, is vital to the success of the community mental health movement.

This thesis tests the link between the perception of fit and response to community mental health facilities for a sample of Toronto residents (n=1090). The perception of fit refers to the individual community resident's perception of how well the facility fits physically into the neighbourhood and how well the facility users fit socially into the neighbourhood. The perception of fit is measured as the perceived impacts of a facility on the neighbourhood, and as the similarity of perceptions of a facility and perceptions of the neighbourhood. In addition, community residents' views about fit are measured in an open-ended question.

Community residents are primarily concerned with the physical characteristics of the facility and its relative location in the neighbourhood. The perception of the fit between a community mental health facility and the neighbourhood varies with respondent awareness of facilities: those aware of a facility in their neighbourhood generally perceive a better fit than those not aware of a facility in their neighbourhood. Attitudinal response to facilities is significantly related to the perception of fit, and can be influenced by the physical characteristics of the facility, by community education, and by the operational characteristics of the facility which control the activities of the facility users.

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CHAPTER 1

Introduction

The mentally ill are increasingly being moved out of the asylum and into small group homes and treatment facilities in the community. The goal in providing these facilities is to integrate them, and the mentally ill, into the mainstream of normal life in the community. This may be expressed as attempting to achieve the best possible fit between form and context, or in this case, a mental health facility and a residential community. The focus of this thesis is on the response of community residents to community mental health facilities, which, it is suggested, will be a function of the individual's perception of the fit between the facility and the community. The central research hypothesis of this thesis suggests that response to community mental health facilities is significantly related to the perception of the fit between a facility and the community. This hypothesis suggests several questions which will be introduced in this chapter, and dealt with in more detail in the chapters to follow.

The first question is: What do the terms community mental health and community mental health facilities refer to? Community mental health refers to the treatment of the mentally ill in a community-based setting. The community mental health movement represents a trend toward the deinstitutionalization of the mentally ill to small scale treatment facilities, for example, residential care facilities

such as group homes and boarding houses, outpatient clinics, and drop-in centres. The goal of the community mental health movement is the re-socialization, or social integration of the mentally ill.

The second question is: Why is public response to community mental health facilities the focus of study? The response of the public to these facilities is important from at least two perspectives. From the mental health perspective, Segal and Aviram (1978) have identified the single most important factor influencing the social integration of the mentally ill as the response of community residents to individual users of a community mental health facility. In a real way, then, the success of the community mental health movement depends on favourable public response. Response to community mental health facilities is also important from a political-planning perspective. The siting of mental health facilities in residential communities has often been associated with community opposition and conflict. Opposition and conflict represent very important responses from a planning perspective for two reasons. First, they may necessitate some form of concession, such as re-building the entrance of a facility at the rear of the building in order to reduce the visibility of the facility users (Dear et al, 1976). Second, they may effectively block the proposed facility location, or force its relocation. This latter outcome has been the source of much criticism of the community mental health movement.

Facilities are often sited in communities with a low potential to conflict. Communities with little or no bargaining power (money, political clout) often generate no conflict and demand no concessions, resulting in what has been termed a "regressive" situation. Often the same segment of the population is involved in these communities, which become the "dumping grounds" for unwanted facilities (Wolpert, 1976). The resulting concentration of facilities in a small geographical area has led to a ghetto-like existence for many of the mentally ill. At this point the community mental health movement may cease to provide a normalizing environment and provide rather, an "asylum without walls" (Wolpert et al, 1975).

The third question arising out of the central research hypothesis is: How has public response to community mental health facilities been studied? Little work has examined response to community mental health facilities per se, rather, such work has been subsumed under the general heading of response to controversial public facilities. Two geographical approaches have been taken to study response to controversial public facilities, including behavioural geography and locational conflict.

The relatively new fields of behavioural geography and environmental psychology have begun to focus on an explanation of individual behaviour in specific environments. Antecedent to an explanation of behaviour is a description of individual

perceptions of the environment. Some work has sought to uncover the images and perceptions of public facilities, including mental health facilities, held by community residents.

Work dealing with community conflict over the location of controversial public facilities has examined the bases or motivations of conflict, conflict strategies, and outcomes in an attempt to identify a process of community conflict. Particularly applicable to this discussion are the bases of conflict, that is, the factors affecting the negative responses of opposition and conflict.

The final question to be raised is: What is the perception of fit and why is it used in this analysis? The idea of fit was introduced by Alexander (1964) who suggested that every design problem should have the ultimate goal of achieving the best possible fit between form (that which is being designed) and context (the area where it is to be sited). Seley (1973) and Dear (1975) have both suggested that in the case of controversial public facilities, the form is the facility, and the context is the host community. Opposition to a facility, and conflict over its location is seen to result from a poor fit between the form and the context. In the case of community mental health facilities, fit may be best defined as the level of integration of a mental health facility and of the facility users in the community. The perception of fit refers to the individual

community resident's perception of how well the facility fits physically into the community, and how well the facility users fit socially into the community. This concept of perceived fit is used in this analysis because, as will be shown below, it is a concept that underlies the approaches previously taken to study response to controversial public facilities.

To summarize, the central hypothesis of this thesis suggests that there is a relationship between the perception of fit and public response to community mental health facilities. Community mental health facilities have been defined; a rationale has been given for examining response to such facilities; an indication of how public response has previously been studied has been presented; and the concept of perceived fit has been briefly outlined.

The second and third chapters provide a more detailed examination of the issues raised above. The second chapter discusses the community mental health movement, outlining its historical context, goals and problems, and the current zoning context. Chapter 3 examines previous research on public response to controversial public facilities, and outlines the perception of fit and its suggested role in affecting public response to community mental health facilities. The fourth chapter presents the research hypotheses, describes the data base, and discusses the measurement of perceived fit and public response to

community mental health facilities. Chapter 5 presents the results of the analysis and chapter 6 concludes with the implications of the findings.

CHAPTER 2

Community-Based Mental Health Care

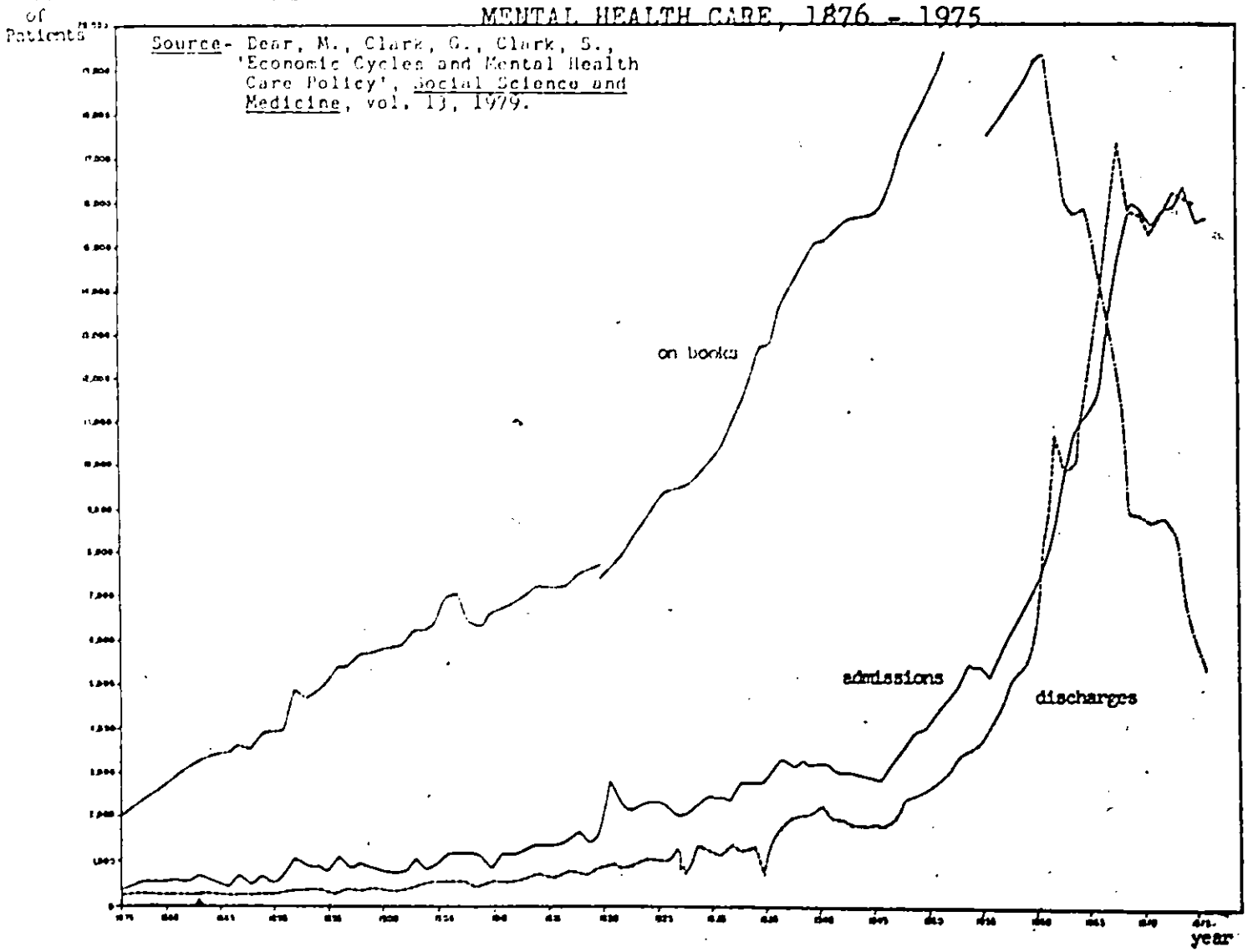
The focus of this chapter is on community mental health. A brief history of mental health care trends in Ontario is given, followed by a discussion of the community mental health movement in theory and practice. This is followed by a look at the current zoning context in Toronto, Ontario, which is the geographical focus for the empirical study discussed in chapters 4 and 5.

2.1 Mental Health Care Trends

Care of the mentally ill in Canada was first undertaken by the religious orders of New France as early as 1639. In Upper Canada, the first asylums were established in the late 1830's and early 1840's, and by 1916, asylums in Ontario accommodated approximately 7,000 people. The asylums were custodial in structure, and quickly became the "dumping grounds" for the insane (Williams and Luterback, 1977). Throughout the period of 1876 to 1960 the trends in Ontario mental hospitals' admissions, discharges, and the number of patients on the books evidenced a constant growth (see Figure 2.1).

In the early 1960's forces were at work in the psychiatric profession in North America and Europe to reverse these trends. There was a growing criticism of the asylum as a form of care,

FIGURE 2.1: PROVINCE OF ONTARIO - TRENDS IN MENTAL HEALTH CARE, 1876 - 1975



Source- Dear, M., Clark, G., Clark, S., 'Economic Cycles and Mental Health Care Policy', Social Science and Medicine, vol. 13, 1979.

and evidence to suggest that long-term incarceration aggravated mental illness. This was paralleled by the suggestion that community-based care would aid the resocialization of the mentally ill. Advances in the use of psychoactive drugs and psychosocial treatment forms contributed to the management and treatment of the mentally ill to the extent that the deinstitutionalization of some mental patients became possible (Klerman, 1976). In 1963 the Kennedy administration in the United States made federal funds available for a program of deinstitutionalization. The consensus of opinion on deinstitutionalization that followed had drastic effects on the mental hospital census in the U.S. (Dear et al, 1979). A similar cost-sharing arrangement was made between the federal and provincial governments in Canada with the same drastic results on the mental hospital census (see table 2.1).

In a very short time, and without prior consideration of the impacts of such a policy, the community mental health movement was thrust into being. At the present time, much of the community-based care of the mentally ill in Canada is under the auspices of the established mental hospitals. Several types of facilities exist, including: outpatient centres where treatment is provided by qualified personnel; group homes, where several mentally ill individuals live together; social therapeutic centres, where programs of therapy are provided ranging from crafts to seminars on how

TABLE 2.1: PROVINCE OF ONTARIO, TRENDS IN PATIENT POPULATION OF PSYCHIATRIC UNITS OF GENERAL HOSPITALS AND COMMUNITY MENTAL HEALTH AGENCIES, SELECTED YEARS 1965-1976

Year	Psychiatric Units			Community Mental Health		
	Adm.[a]	Disch.[b]	Active[c]	Adm.	Disch.	Active
1965	8,515	8,458	617	17,319	16,421	10,042
1970	18,914	18,820	1,118	37,536	33,729	28,156
1974	26,794	26,702	1,340	49,417	47,660	53,637
1976	33,299	32,212	1,798	d	d	d

[a] Admissions

[b] Discharges

[c] Active cases at year end

[d] Unavailable due to a change in official data collection

Source- Dear, M., Clark, G., Clark, S., 'Economic Cycles and Mental Health Care Policy', Social Science and Medicine, vol. 13, 1979.

to cope with community living; and vocational centres where job training is provided for ex-mental patients.

2.2 Community Mental Health

The term "community" in community mental health may refer to two things at once. It may refer first to the physical location of the facilities: the residential neighbourhood. It may also refer to the therapeutic community concept developed as a form of social psychiatric therapy for use inside the asylum (cf. Karasu et al, 1972). Members of a therapeutic community are to provide an accepting, open, caring environment in which the mentally ill are helped back to "normal" social behaviour. For the purposes of this thesis the term "community" will refer to the former and not the latter.

The combination of these two meanings suggests both the potential and the shortcoming of the community mental health movement. The potential is expressed in the principle of normalization: that normal behaviour will result from treatment in a normal setting. Normalization is the watchword for both professional and lobby groups advocating the deinstitutionalization of care for the mentally ill. Normalization defined is:

> The utilisation of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible (Wolfensberger, 1972).

This is to be accomplished by integrating the mentally ill into the mainstream of "normal" life in the community. Integration refers to the physical and social integration of the mentally ill, and to the physical integration of the facilities used by the mentally ill. As such, one of the chief goals of the community mental health movement may be expressed as trying to achieve the best possible fit between the mentally ill, mental health facilities, and the community.

The shortcoming stems from the fact that the community as residential neighbourhood does not always provide a therapeutic setting. This can be explained in terms of the fit between: 1) the facility user and the facility; 2) the facility user and the community residents; and 3) the facility and the neighbourhood. The fit between the facility user and the facility is the concern of the mental health professional in assessing the client's needs, and assigning the client to the appropriate treatment setting. This type of fit is not directly affected by the perceptions of community residents and will not be part of this analysis. The other two types of fit do involve the community residents. A perceived misfit between the facility users and the community residents, or between the facility itself and the neighbourhood could lead to opposition and negative responses toward the facility and the facility users. These negative responses have often been manifest in the exclusion of

the mentally ill or at best, a mere tolerance of their presence in the community. Aviram and Segal (1973) discuss the exclusion of the mentally ill citing a wide variety of exclusionary tactics used by residential communities to block the entrance of the mentally ill into their midst. Their discussion covers such tactics as the use of the penal code to lock the mentally ill away, and the use of restrictive zoning and building standards. These responses do not represent the accepting and open environment prescribed for the re-socialization of the mentally ill, nor do they aid the process of fit between mental health facilities, their users and the community.

2.3 Zoning for Group Homes

Until recently, there have been no comprehensive by-laws in Ontario governing the use of land for the various types of treatment facilities for handicapped groups. As these services have increased in numbers in the past few years, so has the confusion over proper definitions for these community-based facilities. In Toronto in 1977, for example, there were definitions for boys' homes, girls' homes, children's homes, children's shelters, boarding or lodging homes, foster homes, and haven or refuge homes, each with different zoning restrictions. An attempt to locate a facility not covered by these definitions, such as an outpatient clinic, in a residential neighbourhood,

required a special hearing of the Ontario Municipal Board. Such a hearing would inevitably be attended by those in opposition to the facility, ensuring that their views at least were heard. This has meant difficulties in gaining neighbourhood access for mental health facilities. Loopholes in the existing definitions were found, however, and by the mid-1970's certain neighbourhoods in Toronto (Annex and S. Parkdale, for example) found themselves with a concentration of facilities for various handicapped groups, including the mentally ill.

In February 1978, the City of Toronto moved to remedy that situation by passing the first comprehensive group homes by-laws in the province. Under this new legislation residential care facilities, which include group homes, group foster homes, halfway houses, residences for the physically and developmentally handicapped, and special care boarding or lodging houses, are allowed in all residential zones. The facilities may house no more than six persons, and must be spaced at least 800 feet apart. The facilities must meet the housing standards of the host community, and the clients must be referred by a hospital, court, or government agency.

Such a policy facilitates the establishment of community mental health facilities, and clarifies the moral obligation of all communities to care for the mentally ill. Such a policy, however, assumes that these facilities can be

successfully integrated, or fit, into all communities, regardless of social or physical composition. It is not at all clear that this is the case, nor is it clear what the implications of this legislation will be on public response to community mental health facilities.

2.4 Summary

The community mental health movement seeks to treat the mentally ill in the community and has evolved out of a long history of custodial care. One of the chief goals of the movement is to integrate, or fit, mental health facilities and their users into the community. This integration is blocked, however, when community residents perceive that the facility and its users do not fit in their neighbourhood, and act to oppose their location. In an attempt to aid the integration of mental health facilities and their users, new zoning by-laws are being drafted. Although these by-laws provide improved access to residential neighbourhoods, they cannot guarantee community acceptance.

Having established the historical, theoretical, and political context within which community-based mental health care has developed in the Toronto region, attention now focusses on public response to community mental health facilities with reference to the existing research literature.

CHAPTER 3

Public Response to Community Mental Health Facilities

The first section of this chapter focusses on response to controversial public facilities, which is the general topic under which response to community mental health facilities has been studied. Two geographical approaches are outlined, namely, a behavioural approach, and a locational conflict approach. In the second section, these approaches are brought together to study response to community mental health facilities, through the concept of perceived fit. A framework is presented, based on the results outlined in the first section, which details the suggested role of perceived fit in influencing public response to community mental health facilities. The components of the framework are then briefly discussed.

3.1 Response to Controversial Public Facilities

Controversial, or noxious public facilities are those that are generally recognized as necessary, but are not desired at close proximity (Dear et al, 1976). They include, for example, mental health facilities, drug treatment centres, public housing, sewage treatment plants, and urban highways. Two geographical approaches to studying response to controversial public facilities are discussed here. A behavioural approach has been taken to study general

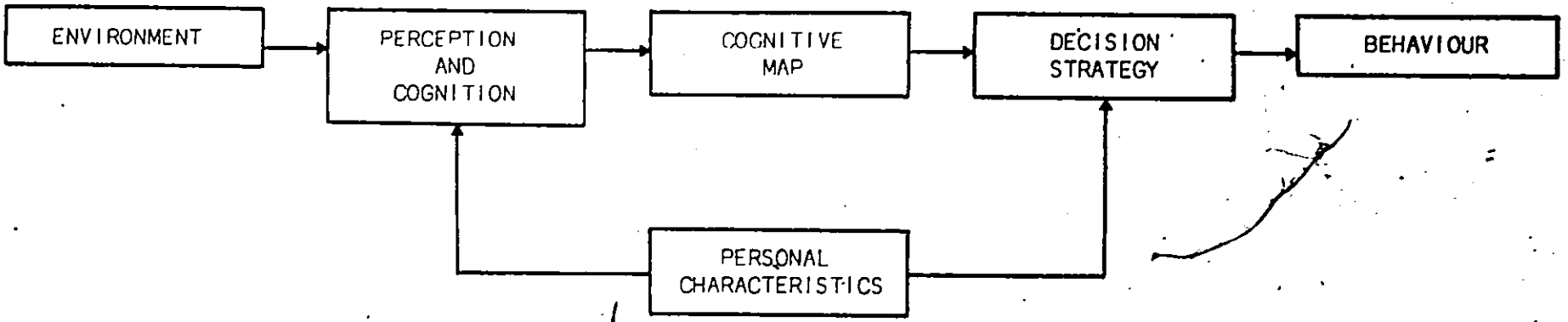
perceptions and evaluations of public facilities. A locational conflict analysis approach has provided an understanding of negative responses to controversial public facilities.

3.1.1 Perceptions of Public Facilities

The relatively new fields of behavioural geography and environmental psychology have begun to focus on an explanation of individual behaviour in specific environments. A basic formula suggests that behaviour is a function of the person and the environment (Koffka, 1935). A fuller specification of this formula leads to the behavioural framework outlined in figure 3.1. The environment is seen as a vast source of information which is selectively perceived, categorized, and organized by the individual. An image or representation of the real environment, comprising much less information than is available in the environment, is stored in the cognitive map, available for recall. It is on the basis of this cognitive image that the individual makes decisions and takes action. The process is an individual one, in that perceptions of the environment and responses to the environment vary with the personal characteristics of the individual. These personal characteristics include socio-economic, demographic and life-style characteristics, as well as beliefs and attitudes.

In behavioural geography, this framework has been the

FIGURE 3.1: BEHAVIOURAL FRAMEWORK



basis of research on individual choice behaviour, especially retail, residential, and transportation mode choice. In each case the environment consists of a series of alternatives, and choice behaviour is based on the perceived attributes of those alternatives.

Within environmental psychology increasing interest has been shown in the general topic of urban perception and cognition. Many studies have focussed on the relationship between the real urban environment, and the urban environment as perceived by different individuals. The link between perceptions of the urban environment and response to that environment has not yet been examined extensively.

Most relevant for this discussion is the work which has sought to uncover the images and perceptions of public facilities held by community residents. Gingell et al (1975) found that the most important dimension used by people in evaluating public facilities was the "degree of noxiousness" associated with the facility. The degree of noxiousness was based on perceptions of the impacts of the facility on the neighbourhood, including how the facility affected property values, enhanced the environment, benefitted the community, and on the kind of people the facility attracted. Dear et al (1976) reported that evaluations of mental health facilities were based on perceptions of the design, condition, and attractiveness of the facility, and its impact on the neighbourhood.

Thouez (1975) suggested that an individual's perceptions of a public facility were based on the meaning of the facility to that individual. The meaning of the facility was measured along the dimensions of evaluation, activity, strength, and familiarity. Sparkes (1976) further examined the meaning of public facilities by looking at the constructs used by individuals to evaluate a facility. He found that different individuals had different perceptions and evaluations of a public facility, and that these differences were attributable to both facility and personal characteristics.

The behavioural approach provides a framework for examining the range of possible responses to controversial public facilities. The emphasis in applying this approach has been on the description of individual perceptions of facilities. To date these perceptions have not been linked with attitudinal or behavioural responses, and making this link is the necessary extension of this work. The factors affecting attitudinal and behavioural reactions to public facilities have been more directly considered, though perhaps in more general terms, within the locational conflict literature which will be the focus of the next section.

3.1.2 Locational Conflict

Locational conflict may be defined as overt public debate over some actual or proposed land use or property development, whether that debate be in the form of public

discussion, referendum, or demonstration (Dear, 1975). Much locational conflict research to date has been carried out on a case-study basis. In each case a particular conflict situation is examined in terms of the motivation or basis of conflict, the conflict strategy taken, and the outcome of the conflict situation. Although a general model of the process of community conflict has yet to be developed, some work has attempted to provide a general description of the motivations behind conflict, and of the strategies available to community groups in conflict situations (cf. Dear and Long, 1977). Given that conflict is one possible response to controversial public facilities, what is relevant to this discussion are the bases of community conflict, or what motivates a conflict situation.

At the most general level, one explanation of community conflict can be found in the theory of residential differentiation. The theory of residential differentiation builds on the theory of social differentiation (Harvey 1975, and Peet, 1975).

The theory of social differentiation suggests that in a capitalist society, the population is divided into distinct social groups or classes by several forces inherent in the process of capitalism. These groups are differentiated according to labour functions, consumption patterns, and mobility chances. These distinct characteristics lead to the reproduction of social groups from generation to generation.

It is further hypothesised that these separate social groups segregate themselves spatially. The process of social differentiation leads to a homogeneity of "life experiences" within social groups, including residential choice, social contacts, and attitudes toward work and education. Thus, social differentiation leads to residential differentiation. It is community consciousness, ground in class consciousness, which then becomes the starting point for conflict. Peet argues that the residents of a particular socially differentiated community are concerned to improve the mobility chances of their children, by improving neighbourhood services, or by migrating to a better neighbourhood. In either case, the concerned resident will attempt to protect the daily life environment from outside influences that might weaken or pollute the resource base of the environment.

That our society is socially differentiated is generally accepted, as is the segregation of socially differentiated groups in distinct residential areas. With respect to public response to community mental health facilities, the theory of residential differentiation suggests that community residents will respond negatively to mental health facilities if they are perceived as a detraction from the general neighbourhood quality. It also suggests that perceptions, attitudes and responses will vary between neighbourhoods, but remain somewhat homogeneous within neighourhoods.

At a more specific level, Dear (1976) suggested that conflict over the location of controversial public facilities was the result of a poor fit between the facility and the host community. Fit, and hence conflict, depended on the characteristics of the facility and of the host community. Facility characteristics included the type of facility, its scale or size, and the degree of noxiousness or perceived negative impacts associated with the facility. Community characteristics included socio-economic status, motivation to participate in conflict, and the range of conflict strategies available to the community residents. As such, the emphasis was on identifying those characteristics influencing conflict, and not necessarily influencing the fit between the facility and the neighbourhood.

Other researchers have suggested that community conflict over controversial public facilities is specifically motivated by the negative external effects associated with the facility. The importance of external effects in motivating conflict is such that it is given detailed consideration below.

3.1.3 External Effects

It is often the case that a planning decision, such as the decision to locate a controversial public facility in a residential neighbourhood produces two sets of outcomes: the anticipated, planned effects, and some unanticipated

side effects. These side effects, or external effects, may be defined as those effects which cause an individual or group to derive benefits or suffer costs from the provision of goods or services to another individual or group (Hill, 1973). In the case of controversial public facilities, external effects may be seen as any facility impacts which are not directly related to the consumption of the good or service which is output from that facility (Dear 1976).

A wide range of external effects may be associated with different public facilities and programs. Downs (1970) examined the un-compensated, non-construction costs associated with urban renewal and urban highways. Taylor and Hall (1977) examined one particular external effect of urban highways, that of traffic noise. Williamson (1970) examined the interference in television reception as an external effect of the construction of the World Trade Centre in New York City. Dear et al (1976) looked at the external effects associated with mental health facilities in Philadelphia. In a broader context, Piven and Cloward (1971) documented the wide range of external effects resulting from the social welfare programs introduced in the United States in the 1960's.

Hill (1973) has classified the external effects arising from the provision of public goods and services as being associated with the following factors: time, as in the peak

traffic flow on an urban highway; collective goods, as in the preservation of land as wilderness areas; altruistic considerations, such as societal provision for future generations; agglomeration, such as urbanization economies or diseconomies; functional interdependence, such as the effect of an urban highway on the use of other public facilities; and jurisdictional effects, or the geographic spillover of the effects of a facility from one region to another.

External effects may be grouped in two ways. First external effects may be perceived as being positive or negative, and second, they may affect the users of a facility, or groups of non-users, who are often the residents of the community in which the facility has been located. The users of a particular facility may experience positive external effects from mixing with other users, through mutual self help and friendship. Users may also experience negative externalities such as being labelled or stigmatized for their use of a socially undesirable facility, as in the case of a mental health facility. Groups of non-users may perceive positive externalities from some types of public facilities, such as urban parks, libraries, or police stations. Negative externalities perceived by non-users include such effects as increased noise from traffic, or decline in neighbourhood satisfaction due to an unwanted facility.

Each of these categories of external effects has a

spatial extent or field of effect, based on how the effects are perceived and experienced by individuals at different distances from the facility. As Cox (1973) suggests, the social undesirable imposes the greatest negative external effects on his immediate neighbours and, houses closer to the factory experience more pollution than houses further away. Such a distance decay effect has been shown to be the case for some public facilities, such as urban parks (Hammer et al, 1971) and urban renewal projects (Rothenberg, 1967). The combination of the spatial field of both the negative and positive external effects of the facility, as perceived by the community residents, defines the net impact of the facility on the community.

A fairly strong theoretical link has been made between the perception of negative external effects, or impact, and opposition to the source facility, leading to conflict over its location. An examination of oppositions to mental health facilities demonstrates this.

Table 3.1 lists types of opposition recorded in the Toronto press for the period of January, 1977 to May, 1978. While newspapers, because of their emphasis on sensational stories, do not represent a reliable index of community response in general, they do provide insight into the subsection of the community opposed to mental health facilities. Each of the oppositions recorded in Table 3.1 is based on non-user perceptions of the external effects of

TABLE 3.1: OPPOSITIONS TO COMMUNITY MENTAL HEALTH FACILITIES RECORDED AT LEAST ONCE IN THE GLOBE AND MAIL OR THE TORONTO STAR, JANUARY 1977 TO MAY 1978

- increase noise
- decrease property value
- increase traffic
- increase parking problems
- poorly run homes in respectable neighbourhoods
- building not maintained
- detract from neighbourhood quality
- detract from neighbourhood stability
- poor administration
- illegal operation
- non-professional care
- lack of supervision
- dislike of facility users
- fear for personal or family safety:
    - fear of arson
    - fear of theft
    - fear of vandalism
    - fear of assault
    - fear of rape
    - fear of murder

the facility, or the perceived impacts of the facility on the neighbourhood. These oppositions can be described in several ways. First, the distinction has been made between those that are tangible (quantifiable), such as increased noise or decreased property values, and those that are intangible (not readily quantifiable), such as fear for personal safety, or dislike of clients (Dear et al, 1976). It is also clear that some of these oppositions are directed primarily towards the facility itself and perceptions of its impact on the neighbourhood, such as building not maintained, while others are directed more towards the facility users, such as attract undesirable people.

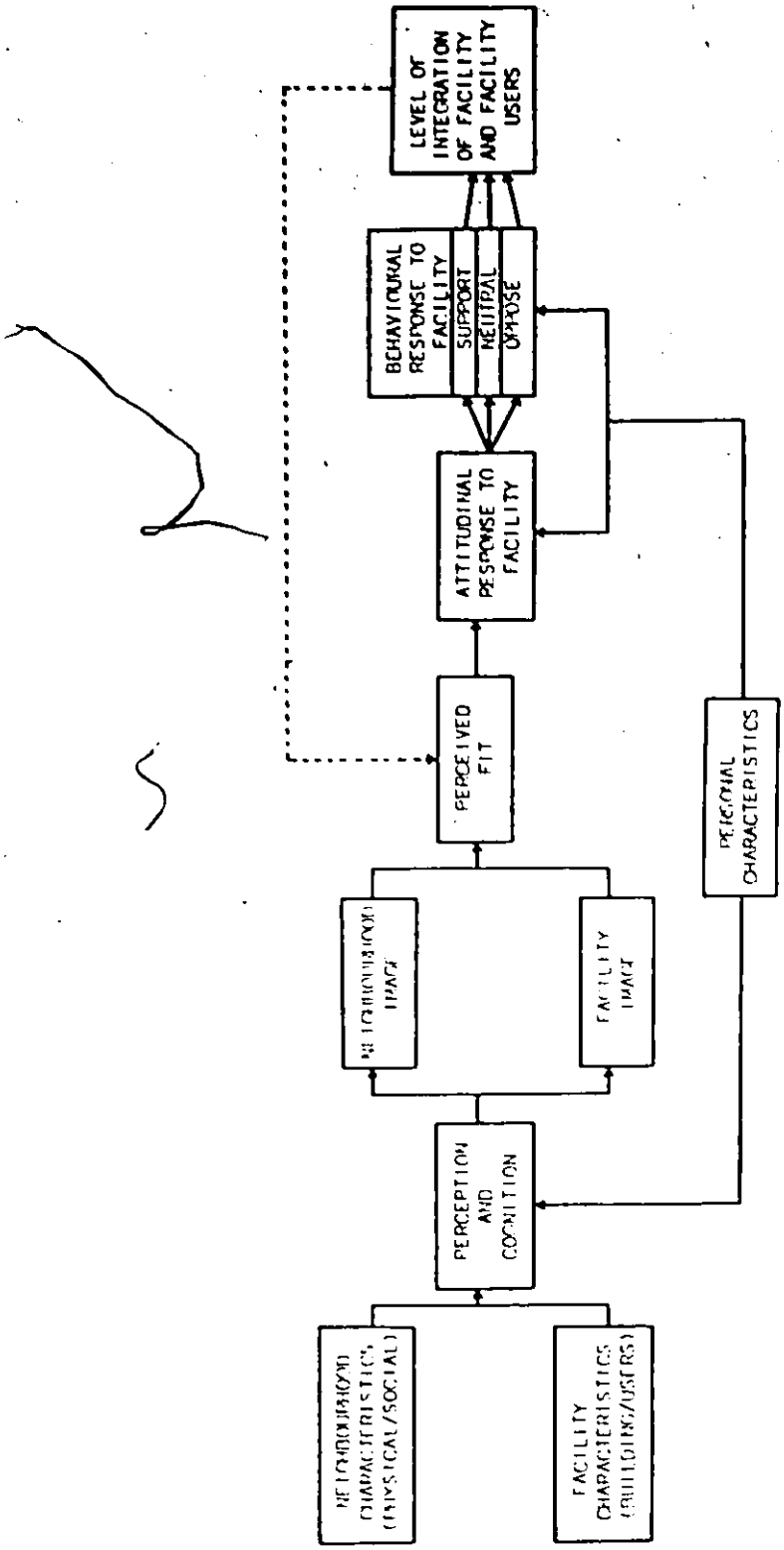
3.2 The Concept of Perceived Fit

The two approaches to studying response to controversial public facilities discussed in the previous section may be brought together to study response to community mental health facilities through the concept of perceived fit. A framework specifying the suggested role of perceived fit in influencing response to community mental health facilities is presented, and explained in light of the research discussed in the section above. The components of the framework are then discussed.

3.2.1 Conceptual Framework

The conceptual framework for this analysis (Fig. 3.2)

FIGURE 3.2: CONCEPTUAL FRAMEWORK



is based on the general model adopted in behavioural geography (Fig. 3.1) and combines elements of the literatures discussed above. It may be explained as follows: the environment consists of the physical and social characteristics of the neighbourhood, and the characteristics of the facility and facility users. These characteristics include not only the objective attributes of the environment, but also the external effects of the facility. Individuals perceive certain of these characteristics and external effects, and develop an image of both the neighbourhood and the facility. Further, these images are compared in determining the perceived fit between the facility and the neighbourhood. Attitudinal and behavioural response to the facility is based on the compared images of the facility and the neighbourhood. Both perceptions and responses will vary with individual personal characteristics, such as socio-economic, demographic and life-style characteristics, beliefs, values and attitudes. The outcome of this process will have an effect on the degree of integration of the facility and its users (cf. Segal and Aviram, 1978) which, in turn, will have a feedback influence on the individual's perception of the fit between the facility and the neighbourhood.

Adopting a behavioural framework, such as this, allows the examination of the full range of responses to community mental health facilities. The suggestion that response is related to the combined perceptions of the facility and

the neighbourhood stems from the results reviewed above. Perceptions of controversial public facilities were shown to be based not only on the characteristics of the facility, but also on the impacts of the facility on the neighbourhood. Conflict motivation was explained first, in terms of the desire to protect the neighbourhood from any influences that would weaken its resource base; second, as the result of a poor fit between the facility and the community, defined in terms of characteristics of both the facility and the community; and third, as the result of non-user perceptions of negative external effects associated with the facility. An examination of oppositions to community mental health facilities revealed that many oppositions were expressed in terms of the impact of the facility on the neighbourhood. All of these results suggest that an individual not only perceives certain things about the facility and the neighbourhood, but that these perceptions are combined and become inseparable in determining the perceived fit between the facility and the neighbourhood.

Perceived fit may be operationalized as perceived impact and perceived congruence. Based on the results reviewed above, perceived fit is first thought of in terms of the perceived impact of the facility on the neighbourhood. Perceived congruence refers to the similarity of perceptions of the facility and of the neighbourhood. As such it is a more general measure of perceived fit,

and one that is closer to the conceptualization of perceived fit as the combination of perceptions of the facility and of the neighbourhood.

Within this conceptual framework, the central link to be tested is that between perceived fit (perceived impact and perceived congruence) and attitudinal response to the facility. Before analysing this link, the other major components of the framework are discussed in the following section.

3.2.2 Factors Affecting the Perception of Fit

The framework presented above suggests that the perception of fit varies with the physical and social characteristics of the neighbourhood, the characteristics of the facility and the facility users, personal characteristics, and, to a lesser extent, the degree of integration achieved by the facility and its users in the neighbourhood.

The physical characteristics of the neighbourhood are thought to include land use mix, housing density, and neighbourhood age. Smith (1976) and Whittman (1979) report that these neighbourhood characteristics may influence the degree of integration achieved by mental health facilities and their users in the neighbourhood. It is suggested that these characteristics may also influence the community residents' perception of fit. For example, mental health facilities might be perceived as fitting better into

neighbourhoods with commercial, rather than residential, land uses; or, into higher density, older neighbourhoods rather than new low density suburban neighbourhoods. Other physical characteristics of the neighbourhood that might influence the perception of fit are suggested by the perceived impacts and external effects of a mental health facility. If mental health facilities are thought to affect neighbourhood quality and the noise, traffic and property value levels in the neighbourhood, then the actual level of the neighbourhood characteristics will influence the perception of fit. A mental health facility might be perceived as fitting better into a neighbourhood accustomed to high noise and traffic levels, for example.

The social characteristics of the neighbourhood are thought to include social mix, social cohesion, and transiency. The theory of residential differentiation suggests that different neighbourhoods will have different perceptions of fit because they vary in social mix. Some evidence for this exists in the work of Trute and Segal (1976) in examining social cohesion, which is a function of social mix. Their results suggest that the integration of mental health facilities and their users may be best achieved in neighbourhoods of middle social cohesion, and not neighbourhoods of high social cohesion (well established, high income) or low social cohesion (slums, skid row). Smith (1976) and Whittman (1979) both report that the degree of transiency

of a neighbourhood will affect the degree of integration achieved by mental health facilities and their users. It is suggested that these social characteristics of the neighbourhood will also influence the perception of fit. For example, mental health facilities might be perceived as fitting better into neighbourhoods with a cross-sectional mix of social groups, rather than in well established or cohesive neighbourhoods; or into neighbourhoods with a high degree of transiency, rather than neighbourhoods that are well established.

Armstrong (1976) reported that the physical, locational, and operational characteristics of a mental health facility may affect the perception of its fit into the neighbourhood. The physical characteristics, such as type, size, design, attractiveness and condition have been stressed above as being important in influencing perceptions of and responses to facilities. Locational characteristics include considerations of nearness to schools or other mental health facilities. The operational characteristics suggested include the screening of facility users on the basis of their ability to cope with community life, and the establishment of minimum staffing requirements, ensuring that a professional is available at all times to supervise the activities of the facility users. Other operational characteristics may be generalized into the quality of care or type of program provided by the facility.

Among the individual characteristics that may affect the perception of fit, the most well researched is attitudes toward the mentally ill. It is suggested that those who hold sympathetic attitudes toward the mentally ill will be more receptive to mental health facilities and their fit in the neighbourhood. Mental health professionals embarked on a public education campaign in the 1950's aimed at improving attitudes toward mental illness by convincing the public that mental illness was an illness like any other. An extensive body of research has evolved since then, examining the effect of the medical model on public attitudes, and identifying the factors affecting attitudes toward the mentally ill. Comprehensive reviews of this literature are provided by Rabkin (1972 and 1974) and Jones (1978). The most important factors affecting attitudes are characteristics of the behaviour of the mentally ill, particularly a combination of unpredictability and violence. Attitudes also vary with the sex and social status of the mentally ill, and with the education and income of the community residents.

Other individual characteristics, such as socio-economic status, demographic and life-style characteristics, and beliefs might affect attitudes toward the mentally ill, and hence the perception of fit. One other individual characteristic is relevant to this analysis. The perception of fit may vary with the level of awareness of mental health

facilities.

It seems reasonable to assume that those who are not aware of a facility will hold different, and possibly incorrect, perceptions of a mental health facility. Those who are aware of a facility at close proximity, however, will be able to form more realistic perceptions of how the facility fits into the neighbourhood.

Apart from neighbourhood, facility, and individual characteristics, it is suggested that the perception of fit will be influenced by the actual degree of integration of the mental health facility and its users in the neighbourhood. Although the response of the community is perhaps the single most important factor affecting the level of integration of the facility and its users (Segal and Aviram, 1978), it is possible that this level of integration may change as the result of other factors, such as the facility user's ability to cope with community life, or the amount of freedom given to facility users. If this were the case, it could affect the community residents' perception of the facility in the neighbourhood.

3.3 Summary

In order to understand how the public responds to community mental health facilities, previous research in the area of response to controversial public facilities has been examined. From a behavioural approach, research

has uncovered perceptions of public facilities. These perceptions include evaluations of the impact of the facility on the neighbourhood. From a locational conflict approach, research has examined the bases of conflict over controversial public facilities. The theory of residential differentiation suggests that conflict is based on community residents' desires to protect the neighbourhood from any influence that would detract from its quality. Other theories stress the importance of the perception of negative external effects in motivating conflict.

These two approaches are brought together in the conceptualization of perceived fit, and its effect on response. Perceived fit refers to the community resident's perception of how the facility fits physically into the neighbourhood and how the facility users fit socially into the neighbourhood. The perception of fit varies with the physical and social characteristics of the neighbourhood, the physical, locational, and operational characteristics of the facility, the attitudes, background, and awareness of the community residents and the actual level of integration of the facility and its users.

CHAPTER 4

Research Design

Chapters 4 and 5 focus on the perception of fit and its role in affecting attitudinal response to community mental health facilities. The first section of this chapter specifies the research hypotheses which will be empirically examined in chapter 5. The remainder of this chapter is devoted to a discussion of the design of a major survey from which the data base for this analysis was taken.

4.1 Research Hypotheses

The central hypothesis of this thesis suggests that response to community mental health facilities is related to the perception of fit between a facility and the community. This general hypothesis leads to the following two specific research hypotheses:

1. There is a significant relationship between the perceived impact of a facility on the neighbourhood, and the rating of the desirability of a facility.
2. There is a significant relationship between the perceived congruence of a facility and the neighbourhood, and the rating of the desirability of a facility.

In addition, it is proposed that community resident awareness of facilities be examined for its effect on both measures of perceived fit by the following research hypotheses:

3. There is a significant difference in the perceived impact of a facility on the neighbourhood in relation to an individual's awareness of facilities.

4. There is a significant difference in the perceived congruence of a facility and the neighbourhood in relation to the individual's awareness of facilities.

4.2 The Toronto Survey

The data used to analyse these hypotheses were collected as part of a major survey of community opposition to mental health facilities in Toronto, Ontario. For a selected sample of Toronto residents, data were collected on individual respondent characteristics, characteristics of the neighbourhood in which they lived, and characteristics of the facility or facilities (if any) located in the neighbourhood. The data were collected over the summer and fall of 1978 by the Survey Research Centre at York University in Toronto.

The sample design is summarized in Tables 4.1 and 4.2. The sampling procedure consisted of two parts: the sampling of potential sites (i.e., without a facility), and the sampling of sites with an existing facility. The sample was stratified according to social class (low, medium, high) and residential location (city, suburb). In the first stage of this cluster sampling procedure, 48 enumeration areas without a facility, and 21 enumeration areas with a facility were

randomly selected (see Table 4.1). In the second stage of the procedure, households were selected randomly from each enumeration area. A total of 1610 households were selected, and 1090 interviews were completed, giving an overall response rate of approximately 68 per cent (see Table 4.2).

Data on perceptions, responses, and other personal characteristics were obtained by questionnaire. The questionnaire was introduced as a general survey of community services (see Appendix A). The first questions were directed at general feelings and opinions about community service, awareness of community mental health facilities in Toronto, and attitudes toward the mentally ill. Respondent perceptions of a mental health facility, the neighbourhood, and the impacts of a facility on the neighbourhood were measured, followed by various measures of respondent reaction to facilities. Finally, the questionnaire measured the individual characteristics of the respondent.

The data relevant to the four research hypotheses specified above are the measures of respondent awareness, perceptions and responses. Awareness was measured on two levels. Respondents were first asked if they were aware of a community mental health facility anywhere in Toronto. Those who were aware of a facility in Toronto were then asked if they were also aware of a facility in their neighbourhood. Based on these responses, a three-fold distinction could be made among those respondents who were not aware of any facilities in Toronto; those aware of a

TABLE 4.1: FIRST STAGE SAMPLE SELECTION: ENUMERATION AREAS

		SOCIOECONOMIC STATUS					
		Without Facility			With Facility		
		Low	Medium	High	Low	Medium	High
LOCATION	Downtown	6	12	6	4	4	4
	Suburb	6	12	6	4	4	1

TABLE 4.2: SECOND STAGE SAMPLE SELECTION: COMPLETED HOUSEHOLD INTERVIEWS

		SOCIOECONOMIC STATUS					
		Without Facilty			With Facility		
		Low	Medium	High	Low	Medium	High
LOCATION	Downtown	93	146	74	77	55	61
	Suburb	114	180	95	50	78	67

facility in Toronto but not in their own neighbourhood, and those aware of a facility in their neighbourhood.

The perception of fit between a facility and the neighbourhood was measured in three ways: qualitatively in an open-ended question, and quantitatively as the perceived impact of a facility on the neighbourhood and as the perceived congruence between a facility and the neighbourhood. Towards the end of the questionnaire (see Appendix A, question 19), all respondents were asked if, in general, they had any suggestions about how mental health facilities could be best fitted into residential neighbourhoods. Responses to this question give an indication of what the respondents think the concept of fit involves, and how it can be achieved.

Perceived impact and perceived congruence measure the perceived fit between a mental health facility and the neighbourhood. The notion of fit as impact is based on the findings presented in chapter 3. Perceived impact was measured by asking respondents to rate the effect they thought a community mental health facility would have (if they were not aware of one in the neighbourhood) or had already had (if they were aware of one) on their neighbourhood. The ratings were measured on twelve separate seven-point, bi-polar scales (see Appendix A, question 10). The specific bi-polar impact scales used were based on the findings of previous research and

included, for example, greatly increase/decrease property values, and greatly increase/decrease traffic on residential streets. Respondents also selected three of the effects they felt were most important.

The notion of fit as congruence is based on the conceptualization presented in Figure 3.2. Perceived congruence measures the similarity of perceptions of the facility and perceptions of the neighbourhood. This required the measurement of respondent perceptions, both of the facility and of the neighbourhood. Several methods have been used to measure such perceptions in past research. Fincher (1975), for example, employed a multidimensional scaling technique (MDS) to measure perceptions of public facilities. Serious questions have been raised, however, as to the uncertain correspondence between the mathematical dimensions of the geometric space output from the MDS analysis and the psychological dimensions within the respondent's minds (Gould, 1976). Sparkes (1976) used a Personal Construct theory approach to measure perceptions of public facilities. The methodology involved in this approach would, at a large scale, present the respondent with such a difficult and tedious research task, that the validity of the constructs identified would be questionable. Thouez (1976) measured perceptions of public facilities using a semantic differential scaling approach. A problem with this approach is the need to establish, a priori, the

salient bi-polar scales.

The preferred method was to use an Adjective Checklist (Gough and Heilbrun, 1965). This method presents the respondent with a standardized list of adjectives from which he checks those that describe his image of, for example, his own personality, a government policy, or an environmental object, such as a mental health facility. This approach is simple, uses everyday language, and makes minimal a priori assumptions. In this case, respondents were asked to read through a list of 78 adjectives and check the ones they associated with the term "community mental health facility". The adjectives were a reduced and modified set from the Environmental Adjective checklist developed by Craik (1971) to measure perceptions of a wide range of environments. Some adjectives were rejected as inappropriate to this situation, and others more appropriate were added. A balance of negative and positive adjectives was sought, and the adjectives were grouped according to the a priori scales summarized in Table 4.3. The choice of scales was based on past research in environmental perception in general, and in public facility perception in particular. Activity and Evaluation are generally recognized as two important dimensions on which perceptions are structured (Osgood et al, 1957). Thouez (1976) suggested that a third dimension, predictability (familiarity) was important in forming perceptions of public facilities. The integration, design,

TABLE 4.3: A PRIORI ADJECTIVE SCALES.

Activity	Evaluation	Safety	Integration	Design	Predictability
calm	appealing	friendly	harmonious	organized	familiar
peaceful	attractive	human	inconspicuous	planned	normal
quiet	cheerful	inviting	unnoticeable	private	ordinary
relaxed	clean	orderly	hidden	residential	permanent
deserted	good	safe	small	accessible	predictable
slow	interesting	sociable		convenient	stable
		sympathetic	conspicuous	well-maintained	
active	bad	welcoming	inconsistent		odd
busy	depressing		contrasting	chaotic	strange
congested	dirty	dangerous	institutional	confusing	uncertain
noisy	repellant	disturbing	out-of-place	commercial	unfamiliar
crowded	rundown	frightening	noticeable	public	unnatural
fast	ugly	inhuman	visible	unplanned	unusual
	unpleasant	tense	big		
		threatening			
		unfriendly			
		insecure			

safety, and predictability scales were also included for their relevance to perceptions of mental health facilities. The dimensions of integration and design are important concerns about the facility itself, and the dimensions of safety and predictability are important concerns about the mentally ill. In order to ensure uniformity in judgement on the adjective checklist, a standard description of community mental health facilities as "out-patient clinics, drop-in centres, and group homes situated in residential neighbourhoods serving the local community" was read to each respondent.

Individual responses to community mental health facilities were measured in several ways. The measure used in this analysis is a rating of the desirability of having a mental health facility within one block of the respondent's home. Desirability ratings were also obtained for two other distance zones from the home: within two to six blocks, and within seven to twelve blocks. Preliminary analysis indicated that these measures produced weaker correlations with perceived fit. Hence, for ease of presentation, only the rating of the desirability of having a mental health facility located within one block of the respondent's home is used in the analysis below.

CHAPTER 5

The Role of Perceived Fit in Affecting Response to Community Mental Health Facilities

Discussion of the analysis is divided into three sections. The first and second sections describe the perception of fit and attitudinal response to community mental health facilities respectively. After this preliminary description of the results, implications for the research hypotheses are detailed in the third section.

5.1 Perceived Fit:

The perception of fit was measured qualitatively in an open-ended question, and quantitatively as perceived impact and perceived congruence. This section describes perceived fit as measured by each of these three methods.

5.1.1 Community Residents' Views About Fit

All respondents were asked the open-ended question: "In general, do you have any suggestions about how mental health facilities could be best fitted into residential neighbourhoods?" All responses were read and coded, and the following discussion summarizes the respondents' views on fit. The responses are also summarized in table form (Table 5.1).

The first point that can be drawn from these responses is that there is generally a low level of familiarity with the concepts of mental health and mental health facilities.

TABLE 5.1: COMMUNITY RESIDENTS' VIEWS ABOUT FIT

Response Categories		Total Population	Per Cent	Not Aware of Facility in Neighbourhood	Aware of Facility in Neighbourhood
1) No Comment		321	26.0	300	21
2) How and Where to House the Mentally Ill:	a) Blend into Neighbourhood	347	29.3	296	51
	b) Visible in Neighbourhood	52	4.4	50	2
	c) Not in Neighbourhood	142	12.0	137	5
	sub total	541	45.7	483	58
3) Factors Affecting Fit:	a) Community	139	11.7	111	28
	b) Facility User	98	8.3	80	18
	c) Facility	86	7.3	71	15
	sub total	323	27.3	262	61
	total	1185	100.0	1045	140

Of the total 1090 respondents, 321 had no comment on this question, and approximately 300 of these were respondents not aware of facilities in their neighbourhood. Many of these said that they simply had no idea, that they had never even thought about the question before. Recall that 388 respondents living in neighbourhoods with facilities were sampled, yet in the final returns, only 139 indicated an awareness of a mental health facility in their neighbourhood. A closer examination showed that others indicated an awareness but were responding to any sort of group homes or drop-in centres near them (for example, special education schools for the mentally retarded, Salvation Army drop-in centres).

The second point is that, among those who did respond, the most common response was about how and where to house the mentally ill. The concern here was about what sort of building would best fit physically into the neighbourhood. The examples that follow give a clear picture of the responses. The two numbers in each case represent the following split in the population: those not aware of a facility in their neighbourhood/those aware of a facility in their neighbourhood. The most common response (251/36) was that the mentally ill could be fit into residential neighbourhoods if housed in ordinary houses (some specified small, others large) that blended physically with the existing nieghbourhood, and therefore were inconspicuous. There were several variations on this theme: 31/4 simply said the mentally ill should be

fit into the neighbourhood as opposed to being institutionalized; 6/3 specified using apartments in the neighbourhood, not houses; 3/1 suggested they be boarded with families; and 5/7 said they thought fit could be achieved by using church or school halls. In this last group, 4 of the 7 respondents aware of a facility in their neighbourhood were from one Scarborough neighbourhood, and referred to the facility in Ionview United Church in a very positive way.

Other respondents were not so community mental health oriented. They were prepared to accept the mentally ill in the neighbourhood but felt that they could only be integrated if there was some clear way of identifying them. For example: 21/0 said the mentally ill could be best fitted in a community centre; 18/0 suggested a medical clinic; 8/0 thought that fit could be achieved in neighbourhood houses as long as a clear sign was erected to indicate that the house was a mental health facility; 2/1 suggested that group homes be established in new neighbourhood, before other people move in; and one person said homes were all right, as long as they were surrounded by high fences.

Still other respondents did not want the mentally ill in residential neighbourhoods at all. This was expressed in different ways: 41/0 said bluntly that the mentally ill simply cannot be fit into residential neighbourhoods; 45/1 wanted to house the mentally ill in a "nice" institution which would be slightly isolated, like a nursing home,

either on the outskirts of the city, or hidden on a large tract of land in the city. The recurring stereotypical response here was that the mentally ill need peace and quiet to recover, they need to be close to nature, and many respondents mentioned a park-like atmosphere with trees, birds and fresh air; 35/4 said mental health facilities should be in commercial areas or shopping plazas; 12/0 thought that the mentally ill should live in houses on the edge or the outskirts of the suburbs; 2/0 felt that they were better off in hospitals; and 2/0 had the very different suggestion of building a new community solely for the mentally ill.

The third point relates to responses that went beyond comments about how and where to house the mentally ill. Some had comments about ways in which fit could be improved. These suggestions can be generalized into three categories: those relating to the community, those relating to the facility users, and those relating to the facility itself. After general considerations of how and where to house the mentally ill, fit is seen by these respondents to depend on the community, then the facility users, and finally the facility itself.

The overriding community factor thought to affect fit was education: 70/18 respondents felt that if the community were educated about mental illness in general, and about mental health facilities in particular, that fit could be

improved. Suggestions included articles in local community newspapers, programs on local cable television, open houses, presentati in schools, and door-to-door flyer distribution. Associated with community education was community involvement: 23/7 thought fit could be improved by involving the community in planning and operating the facility, volunteering to work with individual clients, or simply through sharing recreational facilities. The final community factor involved surveying or asking the community residents before locating a mental health facility in their midst. This suggestion was raised by 18/3 respondents.

Considerations relating to the facility users and their effect on fit were next in frequency of mention. The most important of these considerations (35/12) was that the facility users be adequately supervised and provided with good quality professional care. Enough comments about the activities of unsupervised patients were recorded to stress the importance of this to many individuals. Other considerations included the following: 17/1 felt that only those who were able to cope with community living should be fit into the neighbourhood; 18/2 suggested that fit did not really matter as long as the needs of the facility users were met, such as accessibility to work and transportation; 3/2 had a very different point of view about fit - they suggested that the onus was on the facility users to create fit by becoming involved in the community. It is interesting to note that

3 of these 5 respondents were physically handicapped. Other concerns about the facility users included keeping the number of patients in a facility low (4/1) as one individual suggested: it is easier to accept one individual than "a whole gang"! Some thought (3/0) that fit would be better if there were no uniformed staff; and one individual (a community mental health nurse) stressed the importance of not associating the facility users with either of the two large mental hospitals in Toronto.

Finally, certain considerations about the facility itself were thought to influence fit. Most common among these (43/6) was the concern that the facility be made attractive, and be well maintained. Other concerns included parking: 8/2 were concerned either that too many cars would be parking on the street or that they might have to live next to a parking lot; 4/4 said that concentrations of facilities hindered fit, and that they should be spread out; 7/0 wanted to sneak the facilities in before the community members could react against them; 4/1 mentioned that a friendly atmosphere would aid fit; 3/0 suggested that the facilities be located near existing community services that would already be accepted, such as police and fire stations; 2/0 thought that erecting a sign would reduce fit; and one individual (a special education worker) stressed that the facilities should stay out of basements, and that the facility users should be made visible to the community in

in order to "de-mystify" them.

The fourth point stems from the breakdown of responses between the awareness groups, and is particularly noticeable in the responses about how and where to house the mentally ill. A total of 194 respondents suggested that the mentally ill should somehow be kept separate from the rest of the community. Only 7 of these respondents, however, were from the group aware of a facility in their neighbourhood. This suggests that there may well be a relationship between awareness and response. It also indicates that, by and large, those aware of a facility in their neighbourhood feel that the mentally ill can be fitted into residential neighbourhoods.

To summarize, there are four main points that have been drawn from an examination of responses to this open-ended question of fit: first, there is generally a low level of familiarity with the concepts of community mental health, and community mental health facilities. Second, primary concerns about fit have to do with how and where to house the mentally ill: whether to integrate the facilities into the neighbourhood, have the facilities in the neighbourhood but visible, or not to have the facilities in residential neighbourhoods at all. Of these three the first is the most common response. Third, secondary concerns are about various factors that will affect fit. The first concern is with the community, especially community education; the second concern is with the facility users, especially supervision, and the third is with the

facility itself, especially its attractiveness. Fourth, there appears to be a difference in the responses between those who are not aware of a facility in their neighbourhood, and those who are. Only those not aware feel that mental health facilities cannot be fit into residential neighbourhoods.

These responses represent community residents' views about what is involved in fitting mental health facilities into residential neighbourhoods. Ideally, any measure of community residents' perception of the fit between a mental health facility and the neighbourhood would be based on the responses summarized above. Residents' views about fit, however, were solicited at the same time as perceived impact and perceived congruence were measured. It is interesting, therefore, to see whether or not there is a correspondence between community residents' views about fit and the concepts of perceived impact and perceived congruence.

If a measure of fit between a mental health facility and the neighbourhood were derived based on the responses to the open-ended question about fit, it would include the following three issues: first, and most importantly, how well the facility blends into the existing neighbourhood; second, how attractive the facility is; and third, how closely the facility users are supervised. If the facility building was thought to blend well into the existing neighbourhood, and was thought to be attracitve, and if the facility users were thought to be closely supervised then the facility in question

would be perceived as fitting into the neighbourhood.

Perceived impact provides a reasonable measure of each of these issues. If the facility does not blend into the existing neighbourhood, negative impacts will likely be perceived, such as a detraction from the neighbourhood image, or a reduction in neighbourhood satisfaction. If the facility is not attractive, it will be likely be perceived as detracting from the visual appearance of the neighbourhood. Likewise, if the facility users were not supervised, the facility would likely be perceived as decreasing personal safety.

Perceived congruence provides a better measure of fit in terms of the three issues raised above. If a facility blends into the existing neighbourhood, then it will be perceived as being similar to the neighbourhood. A comparison of separate measures of perceptions of the facility and of the neighbourhood provides an indication of this similarity. A comparison of perceptions will show if the facility is thought of as being safe in relation to the neighbourhood. These comparisons are made more meaningful by examining particular dimensions of the perceptions, such as facility design, or safety. There is then, a good correspondence between community residents' views about fit, and the measures of perceived impact and perceived congruence. These latter two measures will be described in the following two sections.

5.1.2 Perceived Impact

The perceived impact of a facility on the neighbourhood was calculated for each respondent by adding the ratings on the twelve bi-polar impact scales after scoring each scale such that the positive pole had the highest rating. Scores could therefore range from an extreme negative impact of 12 to an extreme positive impact of 84, with a mid-point of 48. Table 5.2 summarizes the mean perceived impact for the total population and for each of the awareness groups. The mean perceived impact for the total population (44.9) is slightly negative, and when divided into awareness groups, little variation is seen. The mean perceived impact is lowest for the group not aware of any facilities (44.1), and highest for the group aware of a facility in their neighbourhood (46.2). A t-test revealed that the mean perceived impacts for these two groups were significantly different ($t = -2.41$, prob. = .016, d.f. = 515). This confirms the third research hypothesis, that perceived impact varies with respondent awareness of facilities. The effect of awareness on perceived impact is similar to the effect on community residents' views about fit described above. Those aware of a facility in their neighbourhood perceive less negative impacts.

The most important impacts for the awareness groups are listed in Table 5.3. The group aware of a facility in their neighbourhood is more concerned with the impacts of

TABLE 5.2: PERCEIVED IMPACT

Total Population		Awareness of Facilities					
		Not Aware		Aware in Toronto		Aware in Neighbourhood	
Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
44.86	8.59	44.13	8.37	45.18	8.17	46.21	8.57

the facility on neighbourhood quality, character, and image. Those not aware of a facility in their neighbourhood place more importance on traffic on residential streets and property values.

5.1.3 Perceived Congruence

Perceived congruence was measured as the difference between the adjective checklist responses for the mental health facility and the neighbourhood. Prior to calculating this difference, two sets of adjective scales were defined. The first set comprised the *a priori* scales previously described (Table 4.3). The second set was defined empirically from a factor analysis of the checklist responses for the mental health facility.

A six factor orthogonal solution was obtained, accounting for 36.3 per cent of the variance. The six empirically derived scales are listed in Table 5.4. The first two scales represent general perceptions or evaluations of mental health facilities. These scales are broad in scope, in that they comprise adjectives pertaining to the safety associated with facility users, and to the design and integration of the facility itself. The fact that the first scale combines positive adjectives and the second combines negative ones suggests that there is a basic dichotomous structure to general evaluations of mental health facilities. The third scale is a design scale representing perceptions of mental health facilities that fit an institutional

TABLE 5.4: EMPIRICAL ADJECTIVE SCALES

Factor 1: Positive Evaluation		Factor 2: Negative Evaluation	
Adjective	Factor Loading	Adjective	Factor Loading
friendly	.717	bad	.614
cheerful	.709	dirty	.591
welcoming	.696	ugly	.575
relaxed	.688	dangerous	.528
inviting	.679	unpleasant	.502
sociable	.660	frightening	.490
harmonious	.657	repellent	.481
interesting	.643	disturbing	.453
well-maintained	.634	inhuman	.433
stable	.622	rundown	.419
attractive	.618	depressing	.418
safe	.608	confusing	.413
peaceful	.607	unnatural	.411
appealing	.606	threatening	.411
good	.599	unfriendly	.400
convenient	.594	insecure	.399
clean	.585	out-of-place	.397
normal	.549	chaotic	.356
orderly	.547	noisy	.353
organized	.530	deserted	.348
planned	.527	strange	.346
human	.526	congested	.338
quiet	.511	tense	.305
familiar	.508	odd	.282
calm	.497	crowded	.281
active	.497	unplanned	.219
accessible	.495	uncertain	.238
residential	.481	conspicuous	.236
permanent	.439	inconsistent	.217
sympathetic	.359		
ordinary	.355		
visible	.345		
public	.325		
predictable	.305		
institutional	-.264		
disturbing	-.207		
depressing	-.326		

NOTE: Adjectives with factor loadings between $\pm .200$ were not included.

(continued...)

Factor 3: Negative Design

Adjective	Factor Loading
busy	.578
crowded	.565
congested	.453
institutional	.407
depressing	.368
chaotic	.338
confusing	.338
tense	.336
noisy	.275
inconsistent	.249
big	.240
commercial	.222
hidden	.221
active	.219
public	.215
fast	.191
calm	-.222

Factor 4: Negative Safety

Adjective	Factor Loading
strange	.542
unusual	.464
odd	.426
unfamiliar	.344
insecure	.338
tense	.295
unnatural	.258
confusing	.249
threatening	.247
disturbing	.227
slow	.220
out-of-place	.212
frightening	.211
inhuman	.210
institutional	.201

Factor 5: Positive Integration

Adjective	Factor Loading
Inconspicuous	.358
private	.355
quiet	.337
hidden	.333
ordinary	.271
predictable	.270
unnoticeable	.267
inconsistent	.237
residential	.230
stable	.209
small	.207

Factor 6: Negative Integration

Adjective	Factor Loading
noticeable	.403
permanent	.383
visible	.382
conspicuous	.316
predictable	.281
disturbing	.259
institutional	.212
contrasting	.188

stereotype. The fourth scale is a safety scale representing perceptions of the mentally ill. The fifth and sixth scales are integration scales representing perceptions of how well mental health facilities are integrated into residential neighbourhoods. These scales indicate that the idea of fit is inherent in perceptions of mental health facilities. Again the fact that the fifth and sixth combine positive and negative adjectives respectively, suggests a basic dichotomy in perceptions of mental health facilities measured on the dimension of integration.

These scales are somewhat different from the a priori scales. Interscale correlations were calculated, based on standardized scores on each scale, and are summarized in Table 5.5. The a priori safety, evaluation, design, and predictability scales correlate with the first empirical scale, positive evaluation (safety .84, evaluation .80, design .70, predictability .62). The same a priori scales correlate on the second empirical scale, negative evaluation. These correlations are negative and weaker (safety -.79, evaluation -.77, design -.56, predictability -.57).

Although none of the a priori scales correlate highly on the third empirical scale, negative design, correlations are highest for the a priori activity (-.68) and design (-.59) scales. The a priori safety scale has the highest correlation on the empirical negative safety scale (-.78). None of the a priori scales correlate highly with the fifth empirical

TABLE 5.5: A PRIORI AND EMPIRICAL INTERSCALE CORRELATIONS

Empirical Scales	A Priori Scales					
	Activity	Evaluation	Safety	Integration	Design	Predictability
+ Evaluation	.3970	.8045	.8379	.4506	.7024	.6194
- Evaluation	-.4321	-.7725	-.7932	-.4621	-.6476	-.5668
- Design	-.6831	-.5749	-.5640	-.4904	-.5884	-.3544
- Safety	-.2939	-.6466	-.7774	-.5121	-.5744	-.6516
+ Integration	.2204	-NS-	.0630*	.3157	.2158	.2749
- Integration	-.2431	-.3773	-.4476	-.7332	-.2914	-.1374

NOTE: -NS- denotes not significant

* denotes significant at the .05 level

All other correlations are significant at the .001 level

scale, positive integration. The highest correlation is for the a priori integration scale (.32). Finally, the sixth empirical scale, negative integration, is highly correlated with only the a priori integration scale (-.73).

Overall, the six a priori scales have been compressed into four broader empirical scales, or dimensions. The first two empirical scales, general evaluations, comprise many more adjectives than the a priori evaluation scale. This suggests that general evaluations of mental health facilities are based on many different considerations, including safety, design, and integration. The empirical design scale is a combination of the a priori design and activity scales. The empirical and a priori safety scales correspond, as do the empirical and a priori integration scales.

Perceived congruence was calculated on each of the scales (a priori and empirical) by taking the numerical difference between the standardized scale scores for the facility and the nieghbourhood checklists. The standardization procedure follows that adopted by Gough and Heilbrun (1965). The first step was to calculate the raw score for each individual for both the facility and the neighbourhood checklists. The raw score was equal to the number of positive adjectives minus the number of negative adjectives out of the total list of adjectives comprising that scale. The raw scores were then standardized according to the following formula:

$$\text{standard score} = \left(\frac{\text{raw score - mean raw score}}{\text{standard deviation of mean raw score}}\right) \times 10 + 50$$

To calculate the standard scores, the population was divided into four percentile groups of equal size for both checklists, based on the total number of adjectives checked. The mean and standard deviation of the group raw scores were then used in the formula, rather than the mean and standard deviation for the total population. Gough and Heilbrun further split the population according to sex and calculated separate scores for each. As a t-test revealed no significant difference in the number of adjectives checked by male and female respondents in these data, this distinction was not made.

These calculations resulted in each individual having a standard score on each of the a priori and empirical scales for both the facility and the neighbourhood. The standard scores all ranged from 0 to 100 with a mean standard score on each scale of 50. The actual score number represents the degree of "positiveness" or "negativeness" of the perceptions of the individual on a particular scale. For example, an individual with a standard score of 62 on the first empirical scale (positive evaluation) for the facility can be said to have a higher than average general evaluation of a mental health facility. If the individual had a score of 35 on the fourth empirical scale (negative safety) for the facility, it could be said that the individual had a higher than average perception of the safety of mental

health facilities and their users.

Perceived congruence was calculated by taking the difference between an individual's standard score for the facility and for the neighbourhood on a given scale. The difference was taken in such a way that in every case a negative congruency value would indicate that the individual's perception of the facility was not as positive as his perception of the neighbourhood. A congruency value of zero on a given scale would indicate perfect congruence between the facility and the neighbourhood. A positive congruency value would indicate that the individual's perception of the facility was more positive than his perception of the neighbourhood on a particular scale.

Table 5.6 summarizes the congruence scores calculated on each of the a priori and empirical scales for the total population and each of the awareness groups. The mean perceived congruence value for the total population, calculated on any scale is close to zero. The nearness to zero of all the means suggests that, across the sample, there is a balance between those who perceive a mental health facility more positively than their neighbourhood and vice versa. The standard deviations show that, assuming a normal distribution, the perceived congruence values fall within approximately $\pm$ 13 points of the mean for 68 per cent of the cases, and within approximately $\pm$ 26 points of the mean for 95 per cent of the cases.

TABLE 5.6: PERCEIVED CONGRUENCE

	Total Population		Awareness of Facilities					
			Not Aware		Aware in Toronto		Aware in Neighbourhood	
Empirical Scales	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation	Mean	Standard Deviation
+ Evaluation	0.16	13.35	0.63	12.59	-1.07	13.91	1.23	13.99
- Evaluation	0.10	13.62	-0.07	13.43	-0.82	14.04	1.98	13.92
- Design	0.21	13.32	0.97	13.33	-1.60	13.71	1.11	13.12
- Safety	0.10	13.52	-0.18	13.82	-0.58	12.69	1.27	11.57
+ Integration	0.01	13.25	-0.79	13.05	0.48	13.44	1.61	14.42
- Integration	0.18	12.87	-0.65	12.81	0.54	12.98	1.24	12.46
A Priori Scales								
Activity	0.16	13.62	0.88	14.35	-1.36	13.02	0.90	13.79
Evaluation	0.18	13.35	0.71	12.84	-1.22	13.70	1.14	14.10
Safety	0.09	13.15	-0.18	13.09	-0.63	13.39	1.67	12.71
Integration	0.09	13.27	-0.78	12.28	0.33	13.64	2.03	13.95
Design	0.08	13.36	-0.31	12.66	-0.84	14.07	1.95	14.19
Predictability	0.02	13.79	-0.10	13.20	-0.23	13.28	0.10	13.47

Examining the effect of awareness on perceived congruence suggests that there is a difference in perceived congruence between those aware of a facility in their neighbourhood, and the other two awareness groups. The mean perceived congruence values for those not aware of any facilities and those aware of a facility in Toronto fluctuate in size and direction, and little can be said about the overall perception of congruence. The mean congruency values for those aware of a facility in their neighbourhood are consistently positive. This indicates that, on average, this group of people perceive a mental health facility more positively than they do their neighbourhoods. This is consistent with the effect of awareness on community residents' views about fit, and on perceived impact.

A t-test revealed that the mean congruence values did not consistently vary significantly with awareness. There was a significant difference calculated on the empirical design scale ($t = -2.41$, prob. = .016, d.f. = 568), and the *a priori* activity scale ($t = 2.05$, prob. = .041, d.f. = 658), between the group not aware of any facilities, and those aware of a facility in Toronto. There was also a significant difference in the mean congruence values calculated on the *a priori* integration scale ($t = -2.20$, prob. = .028, d.f. = 515) between those not aware of any facilities and those aware of a facility in their neighbourhood.

The first two significant differences suggest that the group aware of a facility in Toronto may be responding to something other than a community mental health facility, such as a hospital. This is supported by the fact that this group perceived a poorer fit between a mental health facility and the neighbourhood on the design scales than did the other two groups. The significant difference on the integration scale is important to note because this scale represents the respondents' concern for the issue of fitting mental health facilities into residential neighbourhoods. The difference is such that the group aware of a facility in their neighbourhood perceived a greater fit. On the basis of these results the fourth research hypothesis is rejected: perceived congruence does not vary consistently and significantly with awareness.

5.2 Attitudinal Response to Community Mental Health Facilities

Attitudinal response to mental health facilities was measured as the rating of the desirability of having a mental health facility located within one block of the respondent. Table 5.7 summarizes the median rating of desirability for the total population and for each of the awareness groups. For the total population the median desirability rating of 5.12 was very close to the neutral point on the scale. This is reflected in the percentage of respondents who rated the facility as desirable (31.5 per cent)

TABLE 5.7: THE DESIRABILITY OF COMMUNITY MENTAL HEALTH FACILITIES

	Total Population	Awareness of Facilities		
		Not Aware	Aware in Toronto	Aware in Neighbourhood
Median Rating	5.12	5.29	4.94	4.71
% Undesirable	38.8	43.8	33.2	25.7
% Neutral	29.7	29.7	29.8	30.9
% Desirable	31.5	26.5	37.0	43.4

as opposed to those who rated the facility as undesirable (38.8 per cent).

The median desirability rating for the group of respondents not aware of any facilities was 5.29. Of these respondents, 43.8 per cent rated a facility as undesirable, while 26.5 per cent rated the facility as desirable. For the group aware of a facility in Toronto but not in their neighbourhood the median desirability rating was 4.94. This group was almost evenly split, with 33.2 per cent rating the facility as undesirable, and 37.0 per cent rating the facility as desirable. The median rating of facility desirability for the group aware of a facility in their neighbourhood was 4.71. This group is quite different from the group not aware of any facilities, as only 25.7 per cent rated the facility as undesirable and 43.4 per cent rated it as desirable. A Mann-Whitney U test revealed that the median desirability ratings differed significantly between the group not aware of any facilities and the group aware of a facility in their neighbourhood ($U = 22581$, $z = -4.44$, prob. = .0001). The effect of awareness on attitudinal response to facilities is consistent with the effects of awareness on the measures of perceived fit described above.

5.3 Perceived Fit and Attitudinal Response

The two main hypotheses state a relationship between perceived impact and attitudinal response, and between

perceived congruence and attitudinal response. Table 5.8 summarizes the relationship between perceived impact and the judged desirability of a mental health facility. Kendall's tau was chosen to test the relationship due to the likelihood of tied ranks in both variables.

For the total population there is a significant and moderate positive correlation (tau = .3992, prob. = .001) between the variables. This confirms the first hypothesis, that perceived impact and facility desirability are significantly related. The direction of the relationship is as expected: a higher desirability rating is associated with the perception of a good fit between the facility and the neighbourhood. Among the three awareness groups the relationships are all significant, and the strongest relationship is exhibited for the group not aware of any facilities (tau = .4240, prob. = .001). This suggests that perceived impact is more important to this group in affecting response than to the other two groups aware of facilities.

Of the three awareness groups, the perceived impacts and the desirability ratings are the most negative for this group not aware of any facilities. This suggests that this group of respondents hold certain misconceptions about the effect of a facility on the neighbourhood, which are not held by the other two groups.

Table 5.9 summarizes the relationship between perceived

TABLE 5.8: THE RELATIONSHIP BETWEEN PERCEIVED IMPACT AND FACILITY DESIRABILITY

Total Population		Awareness of Facilities					
		Not Aware		Aware in Toronto		Aware in Neighbourhood	
Tau	Probability	Tau	Probability	Tau	Probability	Tau	Probability
.3992	.001	.4220	.001	.3561	.001	.4129	.001

congruence and the judged desirability of a mental health facility. Again Kendall's tau was used to test the relationship due to the likelihood of tied ranks in both variables. For the total population there is a significant but weak positive relationship between facility desirability and all the scales. This confirms the second hypothesis, that perceived congruence and facility desirability are significantly related. The direction of the relationship is as expected: a higher desirability rating is associated with the perception of a good fit between the facility and the neighbourhood. Considering first the empirical scales, the strongest relationships are with the design, evaluation, and safety scales, with weaker relationships on the integration scales. Of the a priori scales the strongest relationships are on the evaluation, design, and integration scales, with weaker relationships on the safety, activity, and predictability scales.

When broken down into awareness groups, the relationships do not strengthen substantially, and several are not significant at all. Considering the empirical scales again first, for the group not aware of any facilities, the strongest relationship is with the design scale, followed by the evaluation scales. There is a weaker relationship with the integration scales, and no significant relationship with the safety scale. For the group aware of a facility in Toronto the strongest relationships are with the design,

TABLE 5.9: THE RELATIONSHIP BETWEEN PERCEIVED CONGRUENCE AND FACILITY DESIRABILITY

	Total Population		Awareness of Facilities					
			Not Aware		Aware in Toronto		Aware in Neighbourhood	
Empirical Scales	Tau	Probability	Tau	Probability	Tau	Probability	Tau	Probability
+ Evaluation	.1164	.001	.0827	.01	.1486	.001	-NS-	
- Evaluation	.1272	.001	.1134	.001	.1451	.001	.1353	.05
- Design	.1308	.001	.1401	.001	.1560	.001	-NS-	
- Safety	.1141	.001	-NS-		.1359	.001	.0994	.05
+ Integration	.1057	.001	.0962	.05	-NS-		.2098	.001
- Integration	.0814	.001	.0620	.05	.0996	.01	-NS-	
A Priori Scales								
Activity	.0713	.001	-NS-		.0853	.05	-NS-	
Evaluation	.1370	.001	.1211	.001	.1472	.001	.1827	.001
Safety	.1074	.001	.1105	.001	.1107	.01	-NS-	
Integration	.1330	.001	.1127	.001	.1041	.01	.1727	.01
Design	.1363	.001	.1304	.001	.1377	.001	.2256	.001
Predictability	.0845	.001	-NS-		.0723	.05	.1368	.05

NOTE: -NS- denotes not significant.

evaluation, and safety scales. These are followed by weaker relationships with the integration scales. For the group aware of a facility in their neighbourhood the strongest relationship is with the positive integration scale, followed by the negative evaluation scale, and the safety scale.

Considering the individual scales as dimensions on which the perception of fit is based, the following comments can be made about these results. For the two groups not aware of a facility in their neighbourhood, response is most strongly related with the perception of fit calculated on the dimensions of design and evaluation. For the group aware of a facility in Toronto, however, a third dimension, that of safety, becomes just as important. The relationships are quite different for the group aware of a facility in their neighbourhood. The general dimensions of evaluation and design are not as important to this group. Rather, response is most strongly related to the perception of fit calculated on the dimension of integration. To generalize then, the most important concerns of the group not aware of any facilities are general evaluations and design. Safety is an additional concern to those aware of a facility in Toronto. Integration is the major concern of those aware of a facility in their neighbourhood.

This pattern is, to a certain degree, reflected in the a priori scales. For the two groups of respondents not aware of a facility in their neighbourhood, response is

most strongly related with the perception of fit calculated on the design and evaluation scales. Safety is of equal importance to these two groups. For the group aware of a facility in the neighbourhood response is most strongly related to the perception of fit calculated on the dimensions of design and evaluation, as well as integration. This is not consistent with the relationships calculated with the empirical scales. These results, and indeed all of the results pertaining to perceived congruence must be tempered with the following discussion.

An examination of the adjective checklist responses for the mental health facility raised questions about their validity. Table 5.10 reveals that perceptions of a mental health facility, as measured by the checklist, are remarkably similar across all of the awareness groups, and are all very positive. A closer examination uncovered inconsistencies in some checklist responses. For example, several questionnaires were found in which the respondents' attitudes toward the mentally ill were negative, the perceived impacts were negative, the facility was rated as undesirable, yet the adjectives checked to describe a mental health facility were all positive. This suggested that some individuals may have used the adjective checklist to describe what they thought a mental health facility should be like.

This was a problem that was recognized in the pre-test version of the questionnaire. In an attempt to overcome the

TABLE 5.10: ADJECTIVES MOST FREQUENTLY CHECKED TO DESCRIBE A MENTAL HEALTH FACILITY

Total Population	Awareness of Facilities		
	Not Aware	Aware in Toronto	Aware in Neighbourhood
clean	clean	accessible	accessible
accessible	well-maintained	clean	active
well-maintained	accessible	well-maintained	clean
human	human	human	human
friendly	welcoming	active	friendly
active	friendly	friendly	well-maintained
welcoming	active	organized	good
convenient	convenient	welcoming	convenient
organized	organized	good	sociable
good	safe	planned	planned
sociable	sociable	convenient	sympathetic
safe	cheerful	sympathetic	organized
sympathetic	good	sociable	welcoming
planned	sympathetic	safe	safe
cheerful	planned	cheerful	cheerful

problem, the instructions on the checklist were changed from "... put an x beside each adjective you consider descriptive of a community mental health facility", to read "... put an x beside each word you associate with the term community mental health facility". In addition, a standard description of a community mental health facility was read to each respondent (see Appendix A, question 8). This change was apparently not totally successful in eliminating the problem. As a result, the findings of the analysis involving perceived fit measured as perceived congruence are questionable. This might explain why the relationships are weaker than those based on perceived fit measured as perceived impact.

5.4 Summary of Results

The perception of fit refers to the community residents' perceptions of how a mental health facility fits physically into the neighbourhood, and how the facility users fit socially into the neighbourhood. An open-ended question measured community residents' views about fit, and responses to this question revealed four main points. First, the concepts of community mental health and community mental health facilities are not familiar to many people. Second, the primary concern about fit has to do with the type of building to be used, and its relative location in the neighbourhood. Third, secondary concerns are about community education,

facility user supervision, and facility attractiveness. Fourth, only those not aware of a facility in their neighbourhood feel that mental health facilities can not be fitted into residential neighbourhoods.

Perceived impact and perceived congruence measured the actual fit perceived between a mental health facility and the neighbourhood. Generally, a mental health facility is perceived to have a slightly negative impact on the neighbourhood. Those aware of a facility in their neighbourhood perceived, on the average, less negative impacts than the other two groups. This group also placed less importance on the impact of the facility on traffic and property values.

Perceived congruence measured the similarity of perceptions of the facility and perceptions of the neighbourhood. Generally, mental health facilities are perceived as congruous with the neighbourhood. The group aware of a facility in their neighbourhood perceived the greatest congruence.

Attitudinal response was measured as the judged desirability of having a mental health facility within one block of the respondent's home. Those aware of a facility in their neighbourhood are more positive in their rating than the other two awareness groups.

The two major hypotheses were confirmed: there is a significant relationship between both perceived impact and facility desirability, and between perceived congruence and

facility desirability. The strength of the first relationship is moderate, with little variation across awareness groups. The strength of the second relationship is weak, again with little variation across awareness groups.

CHAPTER 6

Conclusions

This thesis has focussed on public response to community mental health facilities. It has been shown that the perception of the fit between a mental health facility and the neighbourhood is of importance in determining that response.

The first section of this concluding chapter examines the implications of the results for the concept of perceived fit, and considers the effect of the level of awareness of facilities on the perception of fit. Implications for the mental health and planning fields are discussed in the second section, and a proposal for further analysis is suggested in the final section.

6.1 The Perception of Fit

Community residents feel that the main issue involved in fitting mental health facilities into residential neighbourhoods has to do with the physical characteristics of the facility. They are concerned first about what type of building will be used, where it will be located in the neighbourhood, and what effects it will have on the neighbourhood. Of secondary importance is the issue of integrating the facility users into the social fabric of the neighbourhood.

Evidence for this can be found in all three measures of fit. Of the responses to the open-ended question about

fit, 53.0 per cent related to the physical characteristics of the facility, while only 8.3 per cent were directly related to the facility users. This is reinforced by the perceived facility impacts chosen as most important, including the effect of a facility on neighbourhood satisfaction, residential street traffic, property values, residential character, and neighbourhood quality. Considerations of the characteristics of the facility users, expressed through impacts such as decrease personal safety, or attract undesirable people, were generally much lower in importance. Finally, attitudinal response to facilities was most consistently related to the perception of fit calculated on the perceived congruence dimension of facility design.

There is a wide variation in the actual perception of the fit between a community mental health facility and the neighbourhood. Both perceived impact and perceived congruence indicate that community residents are quite evenly divided in their perceptions of fit. Roughly the same number of people perceived positive impacts as perceived negative impacts, and roughly the same number of people had more positive perceptions of the facility than the neighbourhood as vice-versa. Because of this variation, it is difficult to draw conclusions about the perception of fit. One way of overcoming this would be to examine the neighbourhood, facility, and personal covariates of perceived fit.

The perception of fit does affect attitudinal response to mental health facilities. Although the relationships between perceived impact and desirability, and between perceived congruence and desirability are significant, neither are very strong. There are two possible explanations for this: first, the measures of perceived fit are inaccurate, and second, other factors, apart from the perceived fit, affect response.

Problems with the measure of perceived congruence were discussed above. Some inconsistent adjective checklist responses may have given rise to an inaccurate measure of perceived congruence, and hence, a weak relationship on this variable. The concept of congruence remains valid, and in all likelihood, the removal of inconsistent responses would lead to stronger relationships.

There are no such problems with the perceived impact measure. One criticism that might be raised against the measure is that the bi-polar scales, chosen a priori, might not be salient. An examination of the correspondence between community residents' views about fit, and the perceived impact measure, however, showed that this was not the case. The emphasis in the perceived impact measure is similar to respondents' views about fit - first and foremost about the facility building and its effect on the neighbourhood, with less emphasis on considerations of safety.

Other factors, apart from the perception of fit, may affect response to mental health facilities. In the conceptual framework presented above (Fig. 3.2) personal characteristics are thought to influence both the perceptual process, and attitudinal and behavioural response to facilities. These personal characteristics may include a whole range of factors, such as socio-economic and demographic variables, life style, beliefs, values, and attitudes. The last is particularly important, as other analyses using these data have shown (Taylor et al, 1979).

Throughout this analysis a distinction has been made between subgroups of the population with different levels of awareness of mental health facilities. The distinction made is between those aware of a facility in their neighbourhood, and those not. This latter group has, for some analyses, been divided into those aware of a facility somewhere in Toronto, and those not aware of any facilities. The effect of this distinction is consistent for each of the three measures of fit, in that more positive responses are shown by the group aware of a facility in their neighbourhood. There are two possible conclusions that can be drawn from these results.

First, it is possible that the group of people not aware of a facility in their neighbourhood hold an incorrect perception of what a community mental health facility is, and what effect it will have on the neighbourhood. This

misconception is corrected by exposure to a mental health facility, as with the group aware of a facility in their neighbourhood. Second, it is possible that those aware of a facility in their neighbourhood are simply resigned to the fact that a mental health facility is there, and change their attitudes and perceptions to be consistent with their situation. Whichever the case, the fact remains that awareness has an important effect on the perception of fit between a mental health facility and the neighbourhood. The implications of this and the other conclusions raised above are discussed in the next section.

6.2 Implications of the Results

In chapter 1 a rationale for studying response to community mental health facilities was given. It was suggested that response was important from both a mental health care perspective and from a political-planning perspective, in that in both cases, negative responses led to undesired outcomes. This analysis has shown that response is influenced by the perception of fit between a community mental health facility and the neighbourhood. The results and conclusion of this thesis also suggest ways in which the fit between a facility and the neighbourhood might be improved, hence leading to more positive perceptions of and responses to community mental health facilities.

First of all, the perception of fit will be influenced

by the physical characteristics of the mental health facility. Ordinary houses or apartments that blend into the neighbourhood will be perceived as fitting best, particularly for group home facilities. Outpatient, social therapeutic or vocational centres might do well in church or school halls, which are already accepted by the community residents. All facilities should be kept attractive, through building maintenance and yard landscaping. The concentration of facilities will influence the perception of fit. From the community residents' points of view, the lower the concentration in one particular neighbourhood, the better they will like it. The parking of cars associated with the facility is another factor that may influence the perception of fit. Although it is true that for many small facilities parking will not be a cause of problems, the community residents should be guaranteed of this. Facilities using church or school halls could make use of the existing parking space.

The perception of fit will also be influenced by the operational characteristics of the facility, especially those that control the activities of the facility users. The community residents will perceive a better fit if they can be guaranteed that the facility users will be well supervised, given good quality professional care, and will not be so disturbed as to be unable to cope with community living. The perception of fit will also be influenced for the better if the facilities maintain a low number of clients, and demonstrate a friendly, non-hospital-like atmosphere.

This thesis has also shown that the perception of fit will be influenced by the community resident's level of awareness of mental health facilities. Increasing the general level of awareness of mental health facilities should help to improve perceptions and responses. This can be accomplished by community education and involvement. Information about mental illness, the community mental health movement, and the particular mental health facility in the neighbourhood can be presented in local community newspapers, on local cable television, through door-to-door flyers, school presentations, and facility open houses. Awareness can also be increased by involving the community in the planning and operation of the facility. Community involvement may also be obtained by a simple thing, such as sharing recreation facilities, or making the facility users visible and encouraging contact with the community residents.

Increasing community awareness through education and involvement may not only help to bring about more positive perceptions and responses, but may also dispel certain misconceptions about mental health facilities. For example, those not aware of a facility in their neighbourhood typically thought that a mental health facility would lower property values, increase traffic, and generally would not fit well into a residential neighbourhood. Those aware of a facility in their neighbourhood did not share the same concerns about property values and traffic, and generally felt that mental

health facilities could be fitted into residential neighbourhoods.

6.3 Further Analysis

As an extension to the work presented in this thesis, further analysis would first improve on the measurement of perceived fit, and second, analyse the effect of neighbourhood facility, and personal characteristics on the perception of fit.

Problems in measuring perceptions in general, and in measuring the perception of fit in particular, were conceded in chapter 3. Two quantitative measures of perceived fit were chosen. Perceived impact was chosen because of its previous use in examining response to controversial public facilities. Perceived congruence was introduced as a method based on the conceptual framework (Fig. 3.2). The problems associated with both measures, particularly perceived congruence, have been discussed. In neither case, however, are they serious enough to warrant the rejection of the concepts of impact and congruence. What is needed is a refinement of the measurement of the relationships between perceived fit and responses to community mental health facilities.

Further analysis would also examine the effect of neighbourhood, facility, and personal characteristics on the perception of fit. One simple way to proceed would be to examine the variations in the mean perceived fit for each

neighbourhood, or for several neighbourhoods grouped together according to some classification of neighbourhood characteristics. A similar approach could be taken to examine the effects of facility and personal characteristics on the perception of fit. In this way profiles of neighbourhoods, facilities, and individuals associated with different perceptions of fit and responses could be compiled.

Allowing for these possible refinements and extensions of the research, this thesis has accomplished its stated objectives. The concept of perceived fit has been operationalized and its role in affecting public response to community mental health facilities examined. The results and conclusions of this thesis have furthered an understanding of how residential communities perceive mental health facilities in their neighbourhood, and how they respond to those facilities. Also suggested are some very practical ways in which more positive responses to mental health facilities might be obtained, by controlling the various facility and community factors affecting the perception of fit. In addition, the results add to the growing body of knowledge about environmental perceptions and behaviour, and about community conflict over the location of controversial public facilities.

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APPENDIX A

'Questionnaire'

SURVEY RESEARCH CENTRE
INSTITUTE FOR BEHAVIOURAL RESEARCH
YORK UNIVERSITY

LABEL

-104-

JUNE 1978

PROJECT # 215

Community Attitudes Toward Neighbourhood Public Facilities

The Survey Research Centre at York University is conducting a study on behalf of a research group at McMaster University in Hamilton. We would like to know your feelings about various community services.

RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	MARITAL STATUS	AGE	ELIGIBLE (18 YRS. & OVER) CODE YES OR NO	PERSON NUMBER	CHECK SELECTED PERSON
(HEAD)						

SELECTION TABLE 12

NUMBER OF PERSONS ELIGIBLE	1	2	3	4	5	6
PERSON TO BE INTERVIEWED	1	2	2	1	3	5

RECORD OF CALLS

	DAY	MONTH	TIME	RESULTS
1				
2				
3				
4				
5				

LENGTH OF INTERVIEW: _____

INTERVIEWER: _____

1 10 20

SURVEY RESEARCH CENTRE
INSTITUTE FOR BEHAVIOURAL RESEARCH
YORK UNIVERSITY

LABEL

PROJECT # 215

1. What is your general opinion about locating community services in residential neighbourhoods? (e.g., community centre, local clinic, police station, fire hall). Are you in favour or opposed?

Favour	1
Indifferent	2
Opposed	3
Don't Know	8

2a. Assuming land was available, are there any particular community services you would favour having located in this neighbourhood?

Yes	1
No	2
Don't Know	8

GO TO Q. 3a

b. If YES, what types?

_____ ___

_____ ___

_____ ___

3a. Are there any particular community services you would oppose having located in this neighbourhood?

Yes	1
No	2
Don't Know	8

GO TO Q. 4a

b. If YES, what types?

_____ ___

_____ ___

_____ ___

1/5

4a. I am especially interested in your feelings about community mental health facilities and the next few questions relate to this. Community mental health facilities include out-patient clinics, drop-in centres and group homes which are situated in residential neighbourhoods and serve the local community. Mental health facilities which are part of a major hospital are *not* included.

Are you aware of any community mental health facilities in Toronto?

Yes..... 1
No..... 2
GO TO Q. 5a

b. Can you name any?

5a. Is there a community mental health facility in your neighbourhood?

Yes..... 1
No..... 2
Don't Know..... 8
GO TO Q. 6

b. What is the name of that facility?

c. Where is it located? *(CLOSEST INTERSECTION)*

6. *IF FROM Q. 5 RESPONDENT IS UNAWARE OF A FACILITY IN THE NEIGHBOURHOOD THEN PHRASE Q. 6 IN THE FUTURE CONDITIONAL (E.G. "WOULD HAVE"); IF AWARE, THEN USE THE PAST TENSE (E.G. "HAS HAD").*

What effects do you think the location of a community mental health facility in your neighbourhood would have/has had?

7. The following statements express various opinions about mental illness and the mentally ill. The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Please circle the response which most accurately describes your reaction to each statement. It's your first reaction which is important.

HAND QUESTIONNAIRE TO R. TO FILL IN

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
S.A.	A	N	D	S.D.

a. As soon as a person shows signs of mental disturbance, he should be hospitalized.

S.A. A N D S.D. —

b. More tax money should be spent on the care and treatment of the mentally ill.

S.A. A N D S.D. —

c. The mentally ill should be isolated from the rest of the community.

S.A. A N D S.D. —

d. The best therapy for many mental patients is to be part of a normal community.

S.A. A N D S.D. —

e. Mental illness is an illness like any other.

S.A. A N D S.D. —

f. The mentally ill are a burden on society.

S.A. A N D S.D. —

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
S.A.	A	N	D	S.D.

g. The mentally ill are far less of a danger than most people suppose.

S.A. A N D S.D. ____

h. Locating mental health facilities in a residental area downgrades the neighbourhood.

S.A. A N D S.D. ____

i There is something about the mentally ill that makes it easy to tell them from normal people.

S.A. A N D S.D. ____

j. The mentally ill have for too long been the subject of ridicule.

S.A. A N D S.D. ____

k. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.

S.A. A N D S.D. ____

l. As far as possible mental health services should be provided through community based facilities.

S.A. A N D S.D. ____

m. Less emphasis should be placed on protecting the public from the mentally ill.

S.A. A N D S.D. ____

n. Increased spending on mental health services is a waste of tax dollars.

S.A. A N D S.D. ____

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
S.A.	A	N	D	S.D.

o. No-one has the right to exclude the mentally ill from their neighbourhood.

S.A. A N D S.D.

p. Having mental patients living within residential neighbourhoods might be good therapy but the risks to residents are too great.

S.A. A N D S.D.

q. Mental patients need the same kind of control and discipline as a young child.

S.A. A N D S.D.

r. We need to adopt a far more tolerant attitude toward the mentally ill in our society.

S.A. A N D S.D.

s. I would not want to live next door to someone who has been mentally ill.

S.A. A N D S.D.

t. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.

S.A. A N D S.D.

u. The mentally ill should not be treated as outcasts of society.

S.A. A N D S.D.

v. There are sufficient existing services for the mentally ill.

S.A. A N D S.D.

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
S.A.	A	N	D	S.D.

w. Mental patients should be encouraged to assume the responsibilities of normal life.

S.A. A N D S.D. ___

x. Local residents have good reason to resist the location of mental health services in their neighbourhood.

S.A. A N D S.D. ___

y. The best way to handle the mentally ill is to keep them behind locked doors.

S.A. A N D S.D. ___

z. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.

S.A. A N D S.D. ___

aa. Anyone with a history of mental problems should be excluded from taking public office.

S.A. A N D S.D. ___

bb. Locating mental health services in residential neighbourhoods does not endanger local residents.

S.A. A N D S.D. ___

cc. Mental hospitals are an out-dated means of treating the mentally ill.

S.A. A N D S.D. ___

dd. The mentally ill don't deserve our sympathy.

S.A. A N D S.D. ___

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
S.A.	A	N	D	S.D.

ee. The mentally ill should not be denied their individual rights.

S.A. A N D S.D. ____

ff. Mental health facilities should be kept out of residential neighbourhoods.

S.A. A N D S.D. ____

gg. One of the main causes of mental illness is a lack of self-discipline and will power.

S.A. A N D S.D. ____

hh. We have a responsibility to provide the best possible care for the mentally ill.

S.A. A N D S.D. ____

ii. The mentally ill should not be given any responsibility.

S.A. A N D S.D. ____

jj. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.

S.A. A N D S.D. ____

kk. Virtually anyone can become mentally ill.

S.A. A N D S.D. ____

ll. It is best to avoid anyone who has mental problems.

S.A. A N D S.D. ____

STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
S.A.	A	N	D	S.D.

mm. Most women who were once patients in a mental hospital can be trusted as baby sitters.

S.A. A N D S.D. ——

nn. It is frightening to think of people with mental problems living in residential neighbourhoods.

S.A. A N D S.D. ——

8. *HAND QUESTIONNAIRE TO R. TO FILL IN*

a. Please read through this list of adjectives and put and X beside each one you associate with the term community mental health facility. Community mental health facilities include out-patient clinics, drop-in centres and group homes which are situated in residential neighbourhoods and serve the local community.

_____accessible	_____hidden	_____slow
_____active	_____human	_____small
_____appealing	_____inconsistent	_____sociable
_____attractive	_____inconspicuous	_____stable
_____bad	_____inhuman	_____strange
_____big	_____insecure	_____sympathetic
_____busy	_____institutional	_____tense
_____calm	_____interesting	_____threatening
_____chaotic	_____inviting	_____ugly
_____cheerful	_____noisy	_____uncertain
_____clean	_____normal	_____unfamiliar
_____commercial	_____noticeable	_____unfriendly
_____confusing	_____odd	_____unnatural
_____congested	_____orderly	_____unnoticeable
_____conspicuous	_____ordinary	_____unplanned
_____contrasting	_____organized	_____unpleasant
_____convenient	_____out-of-place	_____unusual
_____crowded	_____peaceful	_____visible
_____dangerous	_____permanent	_____welcoming
_____depressing	_____planned	_____well-maintained
_____deserted	_____predictable	
_____dirty	_____private	
_____disturbing	_____public	
_____familiar	_____quiet	
_____fast	_____relaxed	
_____friendly	_____repellant	
_____frightening	_____residential	
_____good	_____rundown	
_____harmonious	_____safe	

b. Now please circle the six adjectives in the list which for you are most associated with the term community mental health facility.

9. *HAND QUESTIONNAIRE TO R. TO FILL IN*

a. Please repeat the same procedure to indicate the adjectives you associate with your neighbourhood in general.

_____accessible	_____hidden	_____slow
_____active	_____human	_____small
_____appealing	_____inconsistent	_____sociable
_____attractive	_____inconspicuous	_____stable
_____bad	_____inhuman	_____strange
_____big	_____insecure	_____sympathetic
_____busy	_____institutional	_____tense
_____calm	_____interesting	_____threatening
_____chaotic	_____inviting	_____ugly
_____cheerful	_____noisy	_____uncertain
_____clean	_____normal	_____unfamiliar
_____commercial	_____noticeable	_____unfriendly
_____confusing	_____odd	_____unnatural
_____congested	_____orderly	_____unnoticeable
_____conspicuous	_____ordinary	_____unplanned
_____contrasting	_____organized	_____unpleasant
_____convenient	_____out-of-place	_____unusual
_____crowded	_____peaceful	_____visible
_____dangerous	_____permanent	_____welcoming
_____depressing	_____planned	_____well-maintained
_____deserted	_____predictable	
_____dirty	_____private	
_____disturbing	_____public	
_____familiar	_____quiet	
_____fast	_____relaxed	
_____friendly	_____repellant	
_____frightening	_____residential	
_____good	_____rundown	
_____harmonious	_____safe	

b. Now please circle the six adjectives in the list which for you are most associated with your neighbourhood in general.

10. *HAND QUESTIONNAIRE TO R. TO FILL IN*

a. Now please rate on each of the following 1 - 7 scales the effect you think a community mental health facility would have/has had on your neighbourhood.

greatly increase traffic on residential streets	1	2	3	4	5	6	7	greatly decrease traffic on residential street
greatly increase property values	1	2	3	4	5	6	7	greatly decrease property values
greatly increase personal safety	1	2	3	4	5	6	7	greatly decrease personal safety
greatly increase noise levels	1	2	3	4	5	6	7	greatly decrease noise levels
greatly increase property taxes	1	2	3	4	5	6	7	greatly decrease property taxes
greatly attract desirable people	1	2	3	4	5	6	7	greatly attract undesirable people
greatly enhance the visual appearance	1	2	3	4	5	6	7	greatly detract from visual appearance
greatly increase residents' neighbourhood satisfaction	1	2	3	4	5	6	7	greatly reduce residents' neighbourhood satisfaction
greatly encourage residents to move	1	2	3	4	5	6	7	greatly discourage residents from moving
greatly improve neighbourhood image	1	2	3	4	5	6	7	greatly detract from neighbourhood image
greatly complement residential character of neighbourhood	1	2	3	4	5	6	7	greatly diminish residential character of neighbourhood
greatly upgrade neighbourhood quality	1	2	3	4	5	6	7	greatly downgrade neighbourhood quality

b. PLEASE CIRCLE THE THREE EFFECTS YOU REGARD AS THE MOST IMPORTANT.

11. *HAND R. CARD A.*

How do you rate the desirability of having a community mental health facility located within the following distances from your home?

01. extremely desirable	05. Neutral	06. slightly undesirable
02. considerably desirable		07. moderately undesirable
03. moderately desirable		08. considerably undesirable
04. slightly desirable		09. extremely undesirable
		98. Don't Know

a. ...within 7 - 12 blocks.. ___ ___

b. ...within 2 - 6 blocks.. ___ ___

c. ...within 1 block..... ___ ___

12. *HAND R. CARD B.*

For each location of a mental health facility you have rated as undesirable which of these actions would you most likely take?

a. 7 - 12 blocks..... ___ ___

b. 2 - 6 blocks..... ___ ___

c. 1 block..... ___ ___

13. Have you ever taken any of those actions to oppose the location of a mental health facility in your neighbourhood?

Yes..... 1

No..... 2

14. *ASK Q. 14 ONLY IF FROM Q. 5 RESPONDENT IS UNAWARE OF A MENTAL HEALTH FACILITY IN THE NEIGHBOURHOOD. SEE. Q. 5. OTHERS GO TO Q. 15 A.*

Do you think your attitudes or behaviour would change if a mental health facility was opened in this neighbourhood?

Yes	1
No	2

GO TO Q. 19

15. *ASK Q's 15 THROUGH 18 ONLY IF FROM Q. 5 RESPONDENT IS AWARE OF A MENTAL HEALTH FACILITY IN THE NEIGHBOURHOOD. OTHERS GO TO Q. 19*

a. What is your opinion of the mental health facility in your neighbourhood? Are you

... in favour	1
... or opposed	2
indifferent	3
Don't Know	8

GO TO Q. 16

b. Why are you in favour of/opposed to the facility?

_____

_____

c. *ASK ONLY IF OPPOSED IN Q. 15 a.*

HAND R. CARD B.

Which, if any of the actions listed on this card have you taken? *(CODE 3 ONLY)*

First mentioned	___
Second mentioned	___
Third mentioned	___

16. **Were you living in this neighbourhood before the mental health facility opened?**

Yes..... 1

No..... 2

GO TO Q. 19

17a. **Are you aware of changes in any of your neighbours' attitudes or behaviour since the mental health facility opened?**

Yes..... 1

No..... 2

GO TO Q. 18 a

b. If YES, describe the changes:

_____

_____

_____

18a. Are you aware of changes in your attitudes or behaviour or that of any member of your family since the centre opened?

Yes..... 1

No..... 2

GO TO Q. 19

b. Please describe these changes:

_____

_____

_____

19 *ASK EVERYONE*

In general, do you have any suggestions about how mental health facilities could be best fitted into residential neighbourhoods?

_____

_____

_____

20. Have you or any friends or relatives ever used mental health services of any kind?

Yes	1
No	2
Don't Know	8

And now a few questions about your background.

21. What level of education have you 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

22a. What is your main occupation, that is what sort of work do you do?

_____ ___

_____ ___

b. What sort of business or industry do you work in?

_____

_____

23a. What is the main occupation of the head of the household, that is what sort of work does he/she do?

_____ ___

_____ ___

b. What sort of business or industry does he/she work in?

_____

_____

24. HAND R. CARD C.

Please indicate which range most closely describes the income before taxes of this household in the past year. Just give me the letter from the card.

A.	Less than $5,000	1
B.	$5,000 to $9,999	2
C.	$10,000 to $14,999	3
D.	$15,000 to $19,999	4
E.	$20,000 to $24,999	5
F.	$25,000 to $30,000	6
G.	More than $30,000	7
	Don't Know	8
	Refused	9

25a. Do you attend religious services at least once a month?

Yes	1
No — GO TO Q. 26	2

b. What is your religious group or denomination?

Anglican	01
Baptist	02
Greek Orthodox	03
Jewish	04
Lutheran	05
Mennonite	06
Pentecostal	07
Presbyterian	08
Roman Catholic	09
Salvation Army	10
Ukrainian Catholic	11
United Church	12
Other (SPECIFY) _____	

26. Do you rent or own your residence?

Rent	1
Own	2
Other (SPECIFY) _____	3

27. How long have you lived in this house/apartment? YEARS ___ ___

THANK YOU VERY MUCH FOR YOUR CO-OPERATION

INTERVIEWER CODE:

SEX OF RESPONDENT:

Male	1
Female	2

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TABLE 5.3: PERCEIVED IMPACTS IN ORDER OF IMPORTANCE

Not Aware of a Facility in the Neighbourhood	Aware of a Facility in the neighbourhood
1. neighbourhood satisfaction	1. neighbourhood satisfaction
2. residential traffic	2. neighbourhood quality
3. property values	3. residential character
4. residential character	4. neighbourhood image
5. neighbourhood quality	5. property values
6. neighbourhood image	6. personal safety
7. number of moves out of neighbourhood	7. residential traffic
8. personal safety	8. type of people attracted
9. noise levels	9. visual appearance
10. type of people attracted	10. number of moves out of neighbourhood
11. property taxes	11. noise levels
12. visual appearance	12. property taxes