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What the Neighbors Think: Community Attitudes Toward Local Psychiatric Facilities

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ABSTRACT: We conducted a telephone survey in three boroughs of New York City to assess the impact of proximity to psychiatric facilities on attitudes toward the mentally ill. Six pairs of areas were selected for sampling; within pairs, one area included a facility serving chronically ill psychiatric patients and the other contained no health or mental health facility. Three-quarters of those living within a block of the selected facilities were found to be unaware of their presence. Further, attitudes toward mental illness and patients were not related to proximity to such facilities. These results cumulatively suggest that community psychiatric facilities do not necessarily constitute a personal or community burden as far as the neighbors are concerned.

The public's negative attitudes toward mental patients have been documented extensively in the past 30 years. Social scientists have done so with attitude scales (Rabkin, 1976, 1980; Segal, 1978). Newspaper reporters have written repeatedly about citizens' protests over the presence of large numbers of mentally disabled in their midst. Furthermore, as many as half of all psychiatric facilities planned for residential areas are believed to have been blocked by community opposition (Piasecki, 1975).

Despite this array of evidence, it has never been demonstrated whether such views are modal, shared by most, or whether they belong to a vocal minority, while others remain silent out of indifference, lack of awareness, or tolerance. It is unclear whether negative attitudes about establishment of local mental health facilities are based on actual experiences with such facilities and their clientele, or reflect abstract prejudices. It is also unknown whether negative attitudes toward psychiatric facilities and clientele are specifically towards the

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mentally ill, or are held with respect to other local social services and agencies as well. In short, the role of direct contact and the generality of negative attitudes remain to be clarified in analyzing community response to neighborhood mental health facilities and the presence of the mentally disabled.

The variable of geographic proximity to psychiatric facilities as a determinant of attitudes about mental patients is a central issue in assessment of community attitudes and in the development of policies about community mental health facility locations. If, as a rule, community residents object to having a mental health facility introduced into their neighborhood, one might expect that those already living near such a facility would have more negative attitudes about community psychiatric facilities and mental illness in general, than do those who do not live near a facility.

The literature on this point is meager and inconclusive, although in general, the empirical evidence suggests that "the effect of distance is either small or . . . acts as a surrogate for other variables" (Smith, 1981). In the work of Hall and colleagues (1979), greater distance from mental health facilities was indeed correlated with greater attitudinal tolerance. In contrast, Smith (1981) found greater acceptance of people described as seriously mentally ill expressed by community members living near a mental hospital compared to those who did not. Possible confounding variables in these studies include differences found to be related to attitudes about mental illness such as social class and age of residents, and the possibility that those who live near a mental hospital are more likely than others to work there and thus derive their livelihood from the presence of the hospital. In general, further study of the impact of spatial proximity to psychiatric facilities on attitudes about mental illness seems warranted, and constitutes one of the goals of the present study.

Our other major goal was to assess degree of perceived community burden associated with the presence of local psychiatric facilities in relation to other community problems. In the past, despite the plethora of attitude studies showing various degrees of rejection of mental patients by community respondents, investigators seldom addressed the related question, "Compared to what?" Provision of such a framework facilitates understanding of empirical data. For example, in an effort to interpret the finding that 51% of their community sample said they would consider marriage to a former mental patient, Crocetti and Lemkau (1965) refer to the early work of Bogardus (1928). Bogardus had studied the prejudices of native born Americans toward various racial and ethnic groups. In the course of his studies, he found that 54% of his sample would be willing to marry someone of German descent; in other words, 46% would not consider such a relationship with a member of an ethnic group that was not discriminated against in the late 1920s. Crocetti and Lemkau point out that their finding of 51% acceptance of kinship by marriage to ex-mental patients is comparable to Bogardus' finding of 54% acceptance of German ethnics; in terms of social distance, there is no appreciable stigma reflected by this measure. This kind of comparative statement does seem to be more useful than the simple declaration that a certain percentage of sample

response on a given item does or does not constitute social rejection or stigmatization.

In order to assess the relative perception of community burden related to the presence of local facilities serving psychiatric patients, we conducted a telephone survey of residents in selected areas of 3 boroughs of New York City. Some areas contained facilities used by clients with major mental disorders and others did not. Our goals were to determine prevailing public attitudes toward the presence in the community of visibly impaired people living in transient hotels or using psychiatric facilities, and some determinants of these attitudes.

Our decision to study attitudes of residents in areas with a *single* psychiatric facility was based on three considerations. First, inclusion of several facilities with different characteristics would preclude identification of the individual effects of each. Second, facility clustering within small areas is often an index of community acceptance of such facilities, and we did not want to preselect areas more likely than others to be tolerant. Third, the major policy issue for which we wished to contribute relevant evidence has to do with establishing new facilities in areas without any, both to promote equity of possible community burden and to encourage greater integration of patients into normal neighborhood living.

METHOD

Instrument

We developed a ten-minute telephone survey schedule with multiple-choice response format which covered in sequence the following areas: assets and problems characterizing the respondent's neighborhood; extent of personal participation in community groups; perceived desirability of having different kinds of social and health services in the neighborhood; and then specific inquiries about any known, local psychiatric facility or transient hotel, characteristics of its program and clientele, and the respondent's attitude about its presence. At the end, we inquired about the respondent's socio-demographic characteristics. It was necessary to construct our own survey schedule because no standard instruments covering this material are available in a format suitable for brief telephone interviewing.

Initially, we had hoped to include questions about general attitudes toward mental illness used in standard attitude scales such as the Opinions about Mental Illness Scale (OMI) of Cohen and Struening (1962), but in our pilot work we met strong resistance to such queries. In contrast, respondents were quite willing to report their religious, ethnic, educational, and financial status and other personal information. We therefore decided not to include the attitude scale items.

Sample Selection

Our strategy entailed identification of matched pairs of urban areas similar in terms of social class and business-residential mix, where one area contained a psychiatric facility or transient hotel and the other did not. "Facility areas" were defined as an area including one block in all four directions from the specified facility site. "Control area" is defined as an area of equivalent size and social character at least five blocks away from the nearest facility of any kind and without hotels for transients.

We selected six such pairs of areas, including a pair in the Bronx, one in Queens, and four in Manhattan. In order to see whether type of facility was a relevant variable, we selected two facility areas containing a public outpatient clinic in each, two areas containing small residential facilities for discharged mental patients, and two areas containing a single room occupancy (SRO) hotel known to attract mental patients. The outpatient clinics have 600 and 200 active cases, respectively. The former is located in several ground-floor apartments in a very large high-rise apartment building. The other occupies a small commercial building situated in an area of six-floor apartment houses. One residence, the sole tenant of a brownstone building, has 65 clients. The other, serving eight clients, is an apartment in a high-rise middle income development complex. The SRO's, both hotels in middle class neighborhoods, accommodate 69 and 335 clients, respectively. The matched areas were similar in appearance, housing stock, and degree of commercial activity as reported by census data and confirmed by visual inspection. All facilities served seriously ill and/or chronic adult mental patients. Altogether there were six facility areas and six control areas.

Facilities were selected from directories of social services, and then were visited by one of us (GM) to verify their presence, to rule out the existence of closely adjacent health facilities of any kind or transient hotels, and to ascertain that no major changes had taken place in the facility or control areas regarding census characteristics (median income, ethnic mix, housing density) on which they were matched. It is noteworthy that, despite the presence of hundreds of facilities in this very large city, it was quite difficult to locate areas that met our criteria because of the tendency of psychiatric facilities and SRO hotels to cluster together, to be located near large hospitals, or to be situated in predominantly nonresidential areas.

Once the six facility areas and six matched control areas were selected, we used reverse telephone directories to identify area residents. In facility areas, we interviewed three residents who lived either in the same building as the facility if it was located within an apartment building (this was true for the apartment for psychiatric patients which was in a large housing project, and the larger of the two outpatient clinics) or in buildings immediately adjacent to the facility. In addition, we called five residents who lived around the corner and seven on the block facing either side of the street. Within these buildings and in the control areas, respondents were chosen at random from reverse telephone directories in which listings appear geographically, by address. Fifteen completed interviews were obtained from each of the 12 areas in our study—a total of 90 from residents in "facility" areas and 90 from those in control areas.

Data Analysis

After reviewing total sample frequencies for each item and for composite item sets where appropriate, the following comparisons were subjected to analyses of variance: respondents in facility areas vs. control areas; respondents aware of living near a mental health facility vs. those who were unaware; and those who were both aware of proximity to a facility and who objected to its presence vs. "non-objectors." Additional analyses were based on classification of respondents consecutively by ethnicity, religion and gender. In the following presentation of results, only statistically significant differences are reported.

Feasibility of Method

Respondents almost never declined to be interviewed once we were able to reach them on the telephone. We did, however, have difficulty finding people at home, although calls were made on weekday afternoons as well as evenings. Overall, 80% of randomly selected residents were not at home when called, so that over 1,000 calls were made to obtain 180 interviews in the designated buildings. This procedural inconvenience is more than offset by ease of access to respondents in specific locations and by their minimal refusal rates.

Characteristics of Respondents

A number of sociodemographic characteristics including age, sex, social class, education, occupation and ethnicity have been correlated with variations in attitudes about mental illness (Rabkin, 1976) and so we asked respondents about them at the end of the interview. None dif-

ferentiated between residents near different types of facilities or between those in the three facility areas and three control areas. Accordingly, responses of all "facility" residents are aggregated, as are all "control" residents.

On the average, respondents across locations are middle aged (average age 44), white collar and professional, and well educated (average of two years of college). They had lived at the same address an average of nine years, reflecting a stability far exceeding that of the average American. In general, these respondents are long-term community residents who might be expected to know and care about their neighborhoods.

Since prior contact with psychiatric patients also has been associated with general attitudes, we asked respondents whether they knew anyone "receiving treatment for mental problems." One third acknowledged that they knew someone, and one third also reported having personally recommended mental health services to others. This level of familiarity with psychiatric patients is lower than that reported in other community surveys, in which half to three quarters of respondents admitted previous contact with the mentally ill (Hazleton et al, 1975), probably because our question referred to current treatment only.

RESULTS

The areas covered by the survey include opinions about neighborhood assets and problems, about the desirability of selected social services in the area, and awareness of and attitudes toward local problems serving mental patients. These findings are reviewed in turn. A final section concerns feelings about establishment of psychiatric facilities in the respondent's neighborhood.

Pooling Responses

We designed this study to include three different types of facility in order to get some impression about whether facility characteristics are associated with attitudinal variations. We also selected respondents in three different categories of distance from the facility: in the same building or adjacent building; on the same block face, and around the corner, in order to see whether even within the immediate neighborhood there would be spatial determinants of attitudes. Not only did distance to facility fail to differentiate, but there were no systematic differences in responses from neighborhoods containing different facility types. Accordingly, in all comparisons between facility area residents and control area residents, responses are pooled across facility type; the 90 residents in facility areas and the 90 in control areas are considered in the aggregate.

Neighborhood Assets and Problems

In response to an open-ended query about "the things you like best about living in this neighborhood," the most common response was convenience, followed by safety, attractiveness and congeniality. Facility and control area respondents did not vary systematically in these responses.

Respondents were asked about their estimation of the relative seriousness in their community of nine problems found in some neighborhoods. They were asked to rate each as "not at all a problem," "some problem," or "a serious problem." None of the listed problems were considered serious by even one-third of the respondents in any area. The most commonly cited serious problem was burglary, followed in turn by loitering, teenagers, unemployment and "crazy people in the streets" which about one in six respondents reported as a serious problem. The remaining problems, including drug sales, rundown buildings, alcoholics and drug addicts, were cited by even fewer respondents as "serious" local problems. Only for burglary is the difference between respondent in facility and control areas statistically significant, with more concern expressed by control area respondents. A total score was computed for all problems combined; there were no significant mean differences between respondents in facility and control areas, between those aware of a nearby psychiatric facility and those who were not aware, or between those who objected to the presence of the local facility and those who did not object.

Neighborhood Services

Respondents were asked about the possible local impact of six types of social services. As shown in Table 1, only methadone maintenance programs elicited opposition from a majority of respondents. Slightly less than half thought that the presence of a home for former mental patients would be bad for a neighborhood. Opinion about the impact of a local psychiatric clinic was evenly divided between "bad effect," "no effect" and "good effect." In no comparisons were there significant differences between residents of facility and control areas, either for each category separately, or all combined. Similarly, there were no differences between respondents who were aware that they lived near a psychiatric facility and those who were not. However, people who were aware and who also objected to the presence of the facility did, in general, regard all local social services as having a more negative effect on the neighborhood than did all other respondents.

Awareness of Local Psychiatric Facilities

Although half of the survey respondents were chosen because of their immediate proximity to a psychiatric facility, 77% of them were totally unaware of any program serving mental patients in their neighborhood; 24% of those who in fact lived near a facility correctly identified their presence. On the other hand, 13% of residents selected because they did not live near a facility, incorrectly reported their presence. The responses by facility type are shown in Table 2. In short, although in most cases they lived within actual sight of a psychiatric facility or else around the corner, most people did not know they were there. This is probably our most noteworthy finding.

Among the 34 respondents who reported (correctly or not) the presence of a psychiatric facility in their neighborhood, few regarded the presence either of the facility or the patients as creating local problems. Seven thought the facilities brought undesirable people into the area, ten believed real estate values might be adversely affected, two thought the clients might threaten personal safety, and five thought the area might get a bad name or increased local crime.

TABLE 1: PERCEIVED EFFECT ON NEIGHBORHOOD OF PRESENCE OF SOCIAL SERVICE FACILITIES (% of Respondents)

FACILITY	GOOD EFFECT		BAD EFFECT		NO DIFFERENCE	
	Facility %	Control %	Facility %	Control %	Facility %	Control %
Home for Aged	67	56	3	4	30	40
Recreational Ctr for Teenagers	70	60	10	9	20	31
Home for Former Mental Patients	34	25	48	45	18	30
Home for Mentally Retarded	38	32	31	30	31	38
Methadone Maint. Program	24	18	66	67	10	15
Psychiatric Clinic	39	32	36	35	25	33

When we reconsidered other questions in terms of whether or not respondents were "aware" of the proximity of local psychiatric facilities, we found that more "unaware" than "aware" respondents complained about "crazy people in the streets" (18% vs. 12%), and loitering (23% vs. 12%). Fewer "aware" respondents believed it would be bad for the neighborhood to have a home for former mental patients (35% vs. 48%) or a psychiatric clinic (21% vs. 38%). These differences, although not statistically significant, certainly do not support the hypothesis that awareness of proximity to local psychiatric facilities is associated with greater opposition to them.

When the "aware" respondents were asked to rate degree of personal opposition toward the local psychiatric facility on a scale from 0 (no opposition) to ten (strong opposition), the majority reported no opposition (54%). Only two respondents reported having taken any opposing action to their presence (both lived in control areas so that proximity was evidently not the source of their opposition). Respondents were also asked to describe their neighbors' feelings about local facilities, using the same ten-point opposition scale. They rated themselves as slightly more accepting than their neighbors; that is, they thought their neighbors were less tolerant than themselves. Finally, when asked about community impact of the local facility, most regarded it as negligible.

Attitudes Toward Local Facilities

All respondents were asked whether they thought that "mental patients treated in the community are a danger to people in the area." Eleven per cent were uncertain, 74% did not think so, and 15% (27 people) did think so. This assessment was unrelated to proximity to a facility or awareness of such proximity. Of the 27 who thought patients might be a danger, 25 were unaware of living close to a facility although, in fact, 14 of them did. We could conclude that actual experience is evidently not a determinant of this belief about the danger of mental patients.

Respondents who were not aware of living near a facility serving mental patients were asked three final questions about the theoretical desirability of having local facilities. Three quarters said they would not object to having a mental facility "set up near home." About the same num-

TABLE 2: PERCENT OF RESPONDENTS AWARE OF THEIR PROXIMITY TO A FACILITY SERVING MENTAL PATIENTS.

TYPE OF FACILITY	% of Respondents of Facility Areas (N = 90)	% of Respondents in Control Areas (N = 90)
RESIDENTIAL	17	06
OUTPATIENT CLINIC	53	27
SRO	03	06
TOTAL AWARE	24%	13%

ber who objected to this prospect also objected to such a facility "if it were used *only* by people in your community." Three respondents (2%) said they would work with others to try to have such a facility moved elsewhere; 98% would take no action.

DISCUSSION

The most striking of our findings is the remarkably large number of people living in the same building or on the same block as a facility serving chronically disabled mental patients who were oblivious to the presence of the patients or the facility serving them. More than half of the respondents who were selected because of their actual proximity to such a facility did not know it was there. This finding is similar to that of Dear and Taylor (1979). In their study of Toronto residents, 36% of those selected because they lived within one-quarter of a mile from an existing facility were actually aware of its existence. Our respondents lived on the same block. One is led to conclude that community services do not necessarily constitute a recognized community burden or detract from the quality of life of the neighbors to any substantial degree.

In general, respondents' geographic proximity to psychiatric facilities was not related to attitudes about community services for the mentally ill. Respondents with actual experience based on proximity were no more or less concerned about local problems or the danger of mental patients than those who did not live near such facilities. Our results agree with Smith's (1981) conclusion that the effect of distance from community psychiatric facilities on attitude about them is inconsequential.

A third point of interest is the degree of tolerance toward facilities and their clientele expressed by most respondents. Not only were 90% unprepared to take personal action to block establishment of a "mental facility" near their home, but the large majority were not concerned about the effect of mental patients on personal safety, property values, or neighborhood reputation. In addition, the people who complained about the proximity of a psychiatric facility were also displeased to have other social facilities in the area, suggesting the likelihood of a nonspecific "irritability" factor rather than a particular aversion to the mentally ill.

Finally, it seems worth noting that, in relation to other neighborhood problems, "crazy people in the streets" was of less concern than four others in a list of nine such problems presented to respondents. Evidently, in the context of other problems, the presence of disturbed or disturbing people in the streets is not an issue of central concern, even for community members who live immediately adjacent to facilities carrying as many as 600 active cases at a time.

These results cumulatively suggest that community facilities do not necessarily constitute a personal or community burden as far as the neighbors are concerned. They also support the proposition that community spokesmen opposing current or planned facilities may not actually represent the views of

their neighbors. It is important, however, to note the nature of our sample: we deliberately selected only those areas with a single facility for psychiatric clients, not areas with multiple facilities which, we found, are far more common. These results may, in fact, support the strategy of scattered, rather than clustered facility sites, which may be more easily integrated into the community. This hypothesis is easily tested by replicating this study in areas with concentrated psychiatric facilities to serve as a comparison group.

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