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A REVIEW OF PUBLIC ATTITUDES TOWARDS MENTAL HEALTH FACILITIES IN THE COMMUNITY

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Professor Ron Akehurst, Director

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CONTENTS

LIST OF TABLES

STRUCTURE OF REVIEW

This paper begins with an overview of research into attitudes towards *people* with mental health problems, and moves on to review the literature on attitudes towards *facilities* for people with mental health problems. In order to understand community opposition more fully, the siting of locally unwanted landuses (for example power stations and waste disposal sites) and the phenomenon of 'Not in My Back Yard' (NIMBY) are critically discussed and rival theoretical explanations are explored. Although these theories imply specific means of working with oppositional groups, they do not offer practical recommendations for project planners. The approaches which have been used in the siting of mental health facilities are reviewed to suggest specific strategies to avoid opposition and break down the barriers between planners and the public to achieve positive working relationships. Finally, since the research that has been undertaken in this area is scarce, inconclusive and contradictory, the need for specific investigation into the concerns of a local community, and assessment of factors which exacerbate and ameliorate local concerns is highlighted.

BACKGROUND

The continued movement towards the community based care of people with mental health problems is dependent upon several key conditions: providers of mental health care must offer adequate support and care through comprehensive specialist outreach, day and residential services and through support for ordinary facilities within a locality; the locality must allow people with mental health problems to have access to the facilities and structures used by other community residents in a non-stigmatising, non-discriminatory manner; and in line with the principles underlying community care, people with mental health problems must have the rights of any other citizen, and with appropriate support they must take on normal obligations in relation to the local community.

Where these conditions do not exist, community based care becomes problematic. The quality of life of people with mental health problems is poorer where local hostility is rife or where there is little access to social support. In these conditions they are more likely to relapse (Dear and Taylor, 1982), leading to readmission, a poorer chance of full recovery, less chance of employment, as well as increasing the stigma of mental health problems (Phillips, 1964) and reducing utilisation and acceptance of mental health services by the public at large (Graves *et al* 1971). Although attitudes towards people with mental health problems appear to have become more positive overall in the past three decades (Dear and Taylor, 1982; Hall *et al.* 1993) there is evidence that over this same time period, people who live in the vicinity of planned community mental health facilities have become more hostile, resentful and afraid and can oppose projects so powerfully that they have to be withdrawn (Baron and Piasecki, 1981; SAMH, 1992; MACA, 1994). It seems that public opinion *in principle* bears little relation to local neighbourhood response *in practice*.

Historically, segregation of people with mental health problems was judged appropriate in order to keep this unwanted group out of the public eye (*cf.* Fabrega, 1991), and although a movement away from institutional care may seem preferable to 'experts' on economic or humanitarian grounds, the lay community is unlikely to fully understand the rationale for community care. Indeed, to expect local neighbourhoods to happily take on the role of host to people with mental health problems is to expect them to

adopt a completely new way of thinking (Dear and Taylor, 1982) with little information to guide them (Johannsen, 1969) - other than distorted media presentation.

The Mental Health Foundation (1989) estimates that ninety-nine out of every hundred people with mental health problems now live in the community, but it is the movement of those people who are most dependent, symptomatic or who pose the most risk that remains to be achieved. At the time when opposition appears to be mounting, community facilities are being developed for the clients with the highest needs for community acceptance. It is essential that community opposition to community facilities for people with mental health problems is understood, and that strategies for working effectively with the local community are developed. This will not only facilitate the development of new facilities whose existence is currently jeopardised, but will enhance the lives of people using the services, and in the long term improve public acceptance of people with mental health problems further. As Hall *et al.* (1991) suggest,

> *'taking account of community attitudes towards mental health problems may be crucial to the success of community care. Exceeding the limits of the community's tolerance could lead to the policy 'backfiring' - jeopardising the future of community care and increasing rather than decreasing the stigma attached to mental health problems'* (p302).

ATTITUDES TOWARDS PEOPLE WITH MENTAL HEALTH PROBLEMS

Overview of research

With the movement towards community care, the past three decades have marked a burgeoning interest in community attitudes towards people with mental health problems throughout the U.K., Australia, New Zealand and North America. Over this time, the focus of research has shifted - in line with mental health services - from a general interest in attitudes towards mental illness and psychiatry to a more specific focus on community tolerance of people with mental health problems. However, the bulk of the literature is concerned with factors influencing attitudes towards people with mental health problems, with only a few very recent articles exploring attitudes towards discreet services or facilities for people with mental health problems. Much of the research that has been conducted may now be out of date, but in view of the paucity of more recent evidence, this report cites the more salient work completed in the last three decades.

Overall, the findings are complex and often contradictory, with some studies reporting rejecting attitudes towards people with mental health problems (Cumming and Cumming, 1957; D'Arcy and Brockman, 1976; Steadman and Cocozza, 1978) and others suggesting more positive attitudes (Meyer, 1964; Edgerton and Bentz, 1969; Ring and Schein, 1970) Such divergence in results has been attributed to variation in data collection methods (Macpherson and Cocks, 1983) and the different research methods used by different disciplines (Brockman *et al.* 1979). Thus subjects may be less willing to admit negative attitudes in the presence of a researcher, or open ended questions may give rise to different results to closed questions, and may be interpreted in different ways depending upon the theoretical framework of the researchers. Cowan (1994) points out the importance of taking social contexts into account in the analysis of individuals' attitudes and suggests more discourse analysis as a means of understanding attitudes in a way that might be useful in encouraging further acceptance of people with mental health problems. Certainly, much of the research that has been conducted reports correlations and relationships with little attempt to explain these findings or to examine complex interactional effects. Consequently, although overall findings can be simply described, it is difficult to achieve an in-depth understanding of community attitudes towards people with mental health problems.

Factors affecting attitudes

More tolerance has *most* consistently been found to be associated with: acquaintance with mental health problems (Trute and Loewen, 1978; Taylor and Dear, 1980; Roman and Floyd, 1981; Brockington *et al.* 1993), younger age groups (Rabkin, 1974; Johnson and Beditz, 1981; Sellick and Goodyear, 1985; Brockington *et al.* 1993), higher socio-economic status (Dohrenwend and Chin-song, 1967; Maclean, 1969; Graves et al. 1971; Taylor and Dear, 1981; Brockington *et al,* 1993) and more educated groups (Cumming and Cumming, 1957; Wright and Klein, 1966; Clark and Binks, 1966; Brockington *et al,* 1993). Differences in tolerance of mental health problems have also been found in cross-cultural comparisons (Graves *et al.* 1971; Sue *et al.* 1976; Parra *et al.* 1983; Sellick and Goodyear, 1985).

Not surprisingly, negative reactions are most frequently precipitated by evidence of bizarre, disruptive and possibly dangerous behaviour (Nunally, 1961; Phillips, 1964; Dohrenwend and Chin-song, 1967; Linsky, 1970; Bord, 1971; Rabkin, 1972). This might explain the finding that people with a psychotic diagnosis are viewed more negatively than those with a neurotic diagnosis (Johannsen, 1969; Bord, 1971): serious illnesses are likely to be associated with unpredictable behaviour which is presumably felt to be more threatening. Nieradzik and Cochrane (1979) explored the notion that deviant behaviours are more likely to be tolerated if they are not assigned the label of mental illness (*cf* Scheff, 1975; Mechanic, 1962). They reported a decrease in the public rejection of the mentally ill when a non-deviant alternative label was offered - even in the presence of disturbed behaviour.

Encouraging more favourable attitudes

To inform mental health service planning, and improve the experiences of people with mental health problems, the measurement of attitudes is most useful in the context of studies which seek to encourage more favourable attitudes. Few experimental studies have been conducted in this area, the one notable exception being an early study by Cumming and Cumming (1957). They tested residents of a small Canadian town before and after a six month educational campaign designed to promote more accepting attitudes towards mental health problems. The community rejected the programme on the basis that they could not accept one of the fundamental propositions put forward: that normal and abnormal behaviour fall within a single continuum and are

qualitatively indistinct. Rabkin (1972) suggests that this demonstrates the infeasibility of modifying a specific attitude in isolation from a more extensive and predominant system of values.

Surveys of factors which effect attitudes give some insight into ways in which attitudes might be changed. Although exposure to people with mental health problems seems to be associated with more tolerance (Trute and Loewen, 1978; Taylor and Dear, 1980; Roman and Floyd, 1981; Brockington et al. 1993), contact alone is less effective than contact supplemented by education (Holmes, 1968; Rabkin, 1972). There is tentative evidence that education alone can change attitudes (Dixon, 1967; Graham, 1968) but again, this is most effective in conjunction with personal contact with people who have mental health problems.

Changes in public attitudes over time

The movement towards community care and the concomitant exposure of the public at large to people who have mental health problems might account for the evidence that tolerance and acceptance of people with mental health problems has increased continuously since World War Two. Hall *et al* (1993) offer some support for this notion; in a study of attitudes in two communities with very different mental health services, they report more positive, tolerant and resourceful attitudes among people living in the area served by a community based service. Dear and Taylor (1982) report widespread acceptance in principle of the community mental health movement in the UK. Studies of opinions about mental health problems in four European countries reveal that UK respondents (n=1987) are relatively tolerant and unafraid of people who have mental health problems. Over 72% of UK respondents agreed that community care was 'best', and 78% agreed that more money from taxation should be spent on severe mental health problems (Hall *et al.* 1991).

A more recent survey of 2,000 adults representative of the total population was undertaken in 1993 and repeated in 1994. (RSGB for DOH 1994). This demonstrated that there is a general level of acceptance of people with mental health problems. In 1994 90% or more: believed that a more tolerant attitude towards people with mental illness should be adopted; agreed that people with mental illness deserve sympathy; agreed that we have a responsibility to provide the best possible care for people with

mental illness; and disagreed that increased spending on mental illness was a waste of money.

Despite the general tolerance demonstrated there was, however, significantly more fear of being in contact with people who have mental illness in 1994 than in 1993: in 1994 63% of people agreed that people with mental illness were less dangerous than people supposed (as compared with 65% in 1993); 63% did not agree that it was frightening to think of people with mental health problems living in residential neighbourhoods (as compared with 67% in 1993); and 63% agreed that residents have nothing to fear from people coming into their neighbourhoods to obtain mental health services (as compared with 70% in 1993).

There was a high level of support for community care in 1994. 76% of the population agreed that services should be provided in community facilities and 70% agreed that no-one had the right to exclude people with mental illness from their neighbourhood. But again, there was a hardening of attitudes when compared with 1993. In 1994 60% disagreed that locating mental health facilities in a residential area downgraded the neighbourhood as compared with 65% in 1993 and in 1994 77% agreed that the best therapy for many people with mental illness was to be part of a normal community as compared with 81% in 1993.

This small and specific deterioration in tolerance towards living near people with mental health problems is not only detected in surveys. Groups with practical experience of developing community mental health facilities report increasing hostility towards these initiatives (SAMH, 1992; MACA, 1994). The following section moves from attitudes towards people with mental health problems to review attitudes towards community mental health facilities.

ATTITUDES TOWARDS COMMUNITY MENTAL HEALTH FACILITIES

The extent of community opposition

Although facilities which are seen to be problematic are accorded high profile media coverage (Rabkin *et al,* 1984), those amenities which are developed smoothly and without resistance generally receive little or no publicity which distorts perceptions of the extent of local opposition to community mental health facilities. A more reliable indication of community response to mental health facilities has been gained through surveys of the attitudes of local neighbourhoods: Rabkin *et al* (1984) report that in a survey of people living close to community facilities in New York City, more than half of the respondents were unaware of the existence of the facility. This finding replicates that of Taylor and Dear (1979) who found that only 36% of Toronto residents living within a quarter of a mile of a facility for people with mental health problems knew of its existence.

Yet, public resistance and hostility towards the siting of projects for people with mental health problems in or near their own communities is becoming more common, increasingly powerful, and is often successful in preventing the location, or forcing the closure of needed facilities (Glass, 1989; Dear and Gleeson, 1991; Dincin, 1993; Grassroots, 1994). In the past 10 years, the Mental After Care Association (MACA) have set up 35 houses for people with mental health problems, but it is only in the past three years that they have experienced problems with local residents, and more recently that this opposition has threatened the siting of projects (Bynon, 1994).

The Scottish Association for Mental Health (SAMH), one of the major providers of community care for people with mental health problems in Scotland, also reports an increasingly negative response in some neighbourhoods. This has threatened the viability of several projects and has led to their withdrawal in one case. They subsequently commissioned a report to guide practice in the voluntary mental health movement in Scotland (SAMH, 1992). Further evidence of this phenomena is briefly reported by McCane (1972) who surveyed the development of correctional facilities in the community and stated that the most sensitive issues of all programmes studied was the reaction of the community. Baron and Piasecki (1975) suggest that as many as half

of all psychiatric facilities planned for residential areas are believed to have been blocked by community opposition. But, as Sundeen and Fiske (1982) comment, although it is apparent that resistance occurs and can be intense, there are no systematic or comprehensive studies of the extent of the resistance, its precise nature, or how it is dealt with. Nevertheless, the vehemence and effectiveness of local opposition towards certain facilities in particular neighbourhoods is somewhat surprising in view of the general level of tolerance and acceptance reported in surveys of attitudes. As Rabkin (1972) warns,

> *'One of the most germane considerations in the study of attitudes about mental health problems is their relationship to behaviour....Few investigators in this or any other area have been able to demonstrate a straight forward relation between attitude and behaviour, or between attitude change and behavioural change, although this relationship is largely taken for granted by most social scientists'* (p.167).

Certainly, the acceptance that is reported in principle does not appear to be demonstrated in practice. Perhaps as a result, more recent research into community attitudes towards people with mental health problems has begun to focus on the relationship between community context and negative attitudes towards people who have mental health problems (Segal and Aviram, 1978; Sigelman *et al.* 1979; Segal *et al.* 1980; Evans et al, 1981; Dear and Taylor, 1982; Sundeen and Fiske, 1982; Rabkin et al, 1984; Cheung, 1990; Wenocur and Belcher, 1990; Dear, 1992 SAMH, 1992). Although the bulk of this literature refers to the situation in the U.S. and Canada, the following section presents a review of the main findings to facilitate some understanding of the nature of community opposition.

The nature of community opposition

The main channels of opposition and complaint are public meetings and hearings set up to deal with objections (Lauber, 1990). Opposition power is usually based on land-use or zoning; most human services facilities in residential districts do not comply with the land use designated for that area so a variance is needed which calls for the immediate neighbours to be informed. Where the proposed development appears to be within designated land use regulations, local opposition often challenges the land

use classification given to the facility (for example a clinic may be classified as commercial, retail or industrial) (Dear and Wolch, 1987).

Opponents also apply pressure through petitions, marches, involvement of politicians and the media, formal neighbourhood opposition groups and strategies. Although physical damage to property and people is rare, the psychological effects of local hostility is far-reaching for the staff and the clients using or proposing to use a planned facility (Segal *et al,* 1980; Dear and Taylor, 1982; SAMH, 1992).

The arguments most frequently expressed in community opposition reflect three main concerns (Dear and Taylor, 1982; Solomon, 1983; Sundeen and Fiske, 1992; Dear, 1990; Wenocur and Belcher, 1990; Dear, 1992): perceived threat to property values, fear, and threat to neighbourhood amenities.

Perceived threat to property values.

Although this is a common source of opposition to the development of new projects, with neighbours even seeking a reduction in tax rates because of an alleged drop in property values (Boydell, 1989), careful research has consistently found that property values have not been effected by the development of human service facilities in the vicinity (Wagner and Mitchell, 1980; Goodale and Wickware, 1981; Dear and Taylor, 1982; Boydell *et al.* 1989).

Concerns about personal security.

Such fears are commonly expressed in questions about the supervision of clients. These are more common if clients are perceived to be dangerous or unpredictable, for example ex-offenders, drug addicts, or people with serious mental health problems (Dear and Laws, 1986; Cheung, 1990; Lee *et al.* 1990; Dear and Gleeson, 1991; Dear, 1992).

Threat to neighbourhood amenities.

Local businesses and residents worry about the effect of anti-social or unkempt people upon the quality of the area. Specific concerns include the likelihood of public urination or defecation, people loitering in the vicinity, and the bad influence of these people on children - and on business.

The public face of local opposition often appears altruistic, key people might be put forward to represent particular view points, for example mental health care workers opposed to residential accommodation for people with mental health problems in their area have expressed their concern in terms of the clients' needs (Dincin, 1993), local policemen have warned of the danger of clients being burgled if it is known that they are on prescription drugs (Sundeen and Fiske, 1982).

Factors affecting community attitudes

Dear (1992) emphasises that geographical proximity is the one universal factor in all local siting conflicts,

> *'The rule is simple: the closer residents are to an unwanted facility the more likely they are to oppose it. Opposition runs high among those on the same block as a proposed facility. Two to six blocks away, neighbours interest or awareness declines to the point of indifference (Dear et al, 1980). This rule should be obvious but its impact should never be underestimated'* (p.291).

There are four other factors which contribute to the way a local community responds to plans to open a facility in the vicinity: client characteristics; facility characteristics; structure of the host community, and community relations with service planners (Coates and Miller, 1971; Segal and Aviram, 1978; Segal *et al.* 1980; Dear and Taylor, 1982; Sundeen and Fiske, 1982; Dear and Wolch, 1987; Glass, 1989; Dear, 1992).

Client characteristics

Tringo (1970) describes public attitudes towards difference as a hierarchy: the elderly and people with physical disability are most easily accepted because these are problems which anyone might encounter in their lives; people with learning disabilities are in the middle of the range; people with mental health problems are less easily accepted (this hierarchy was more recently confirmed by Solomon, 1983). Dear, (1992) suggests this might be due to their perceived culpability as the least acceptable groups are those with 'social diseases' such as criminals, drug addicts and alcoholics. Dear and Laws (1986) demonstrate the significance of the client type in gaining acceptance of the local community: new laws in Canada allow all kinds of group homes into residential neighbourhoods as of right, except correctional facilities designed for the rehabilitation of convicted offenders.

residential neighbourhoods as of right, except correctional facilities designed for the rehabilitation of convicted offenders.

Fattah (1984) describes the recent hardening of attitudes towards criminals giving evidence of rapidly mounting punitiveness towards offenders. She suggests underlying reasons for these negative reactions which have some relevance in the consideration people with mental health problems: rising crime rates given wide but distorted publicity by the media (paralleled by the media hype accorded homicides committed by people with mental health problems as compared with other homicides); demographic changes with a rise in older age groups who are less accepting of offenders - and people with mental health problems; and economic uncertainty, leading to

> *'... a search for scapegoats who can be blamed for the countries' ills and on whom sentiments of fear, hostility and frustration can be projected... Minorities, immigrants and criminals have traditionally served this function in times of crisis" (p375).*

Facility characteristics

The characteristics of a proposed facility are important in terms of the direct impact that it has on the local community, and the potential to change as requested by the local community in order to gain acceptance. Table 1. shows the six main dimensions that influence community perceptions (Weber, 1978; Segal and Aviram, 1978; Segal et al, 1980; Dear and Taylor, 1982; Sundeen and Fiske, 1982; Dear, 1992).

Characteristics of the host community

Wenocur and Belcher (1990) suggest that existing research indicates that communities are more likely to oppose new projects where there exist politically conservative values, a high degree of social cohesion, strong neighbourhood associations and outspoken leader, and a preponderance of owner occupied, single family dwellings. Suburban communities have been found to be less tolerant than inner city areas (Segal *et al.* 1980; Dear and Taylor, 1982). The explanation for this appears to lie in the level of social and physical homogeneity within a community: homogeneous communities tend to reject difference, whereas mixed and transient communities hardly notice it (Segal and Aviram, 1978). There are no reports of opposition to mental health facilities in rural areas, it is not clear whether this is due to no attempts being made to site facilities in

Table 1. Six dimensions of the facility that influence community perceptions

Type:

Residential facilities are usually less acceptable than non-residential facilities which make fewer demands on the local community within limited hours and do not imply such a disabled client group; services for the local population are more popular than those seen to attract strangers; acceptability will depend to a large extent upon the client group.

Size:

Since larger facilities introduce more noise, traffic, disruption, activity, smaller facilities are generally more acceptable. An exception would be a large facility bringing improved employment prospects.

Number:

Communities are more likely to resist new facilities either if it is the very first in the area (and as such might herald more), or if the community perceives itself to be overburdened.

Operation:

Community attitudes are strongly influenced by the level of assurance that can be given with regard to security and safety.

Reputation:

The reputation of the agency can enhance community attitudes particularly if successful examples of similar projects can be cited, or if they are supported by a respected politician or celebrity.

Appearance:

Neighbourhood anger can be defused by careful attention to the design of internal and external spaces so that the facility is screened and an institutional appearance is avoided. The name of the facility and the type of sign can create anxiety and tension if they are obtrusive or explicit.

rural communities, or to a difference between rural and urban populations. (But in one of the very few studies which considers community attitudes towards people with mental health problems, Bentz *et al.* (1969) reported no difference between rural and urban communities.)

A US national survey conducted in 1989 described the typical opposer as affluent, male, well educated, professional, married, a home owner, and living in the suburbs (Dear, 1992). Interestingly, this contradicts the findings cited earlier in this paper, (that less educated people in lower socio-economic groups express less tolerant attitudes towards people with mental health problems), and perhaps indicates the gap between attitudes and behaviour. However, the practical experience of people interviewed for the SAMH report (1992) indicated that some projects set up in just such affluent, suburban areas had been welcomed, whilst opposition had been experienced in areas of public sector housing. As Wenocur and Belcher (1990) suggest ,

> *'no simple formula for community acceptance can be proposed; it will vary by project and target community...The process of developing community support needs to be treated as an experiment in deliberate social change' (p332).*

An important characteristic of the host community is the level of concentration of community care facilities. In the US there has been a tendency for planners to seek low risk sites where tolerance is high, landuse regulations most flexible, and property values and rents are low. This has, however, led to ghettoisation of services in inner city districts where there is a mix of deteriorating multi-occupation housing and commercial and residential landuses, few community resources to meet the needs of the population, and often high levels of poverty, crime, alcohol abuse and transience (Segal *et al.* 1980; Dear, 1992; Sundeen and Fiske, 1982; Weisberg, 1994). Sundeen and Fiske (1982) list the potential problems of an over-concentration of human resource facilities: clients may confine their relationships to others with similar problems and thus opportunities for normalisation are reduced; visibility of clients is increased which might exacerbate negative reactions towards them; and over-concentration in less affluent areas allow other areas to avoid any responsibility for needy groups. However, Dear and Wolch (1987) suggest that this ghettoisation is not without advantages for both clients and service operators. For people with mental health problems, the stigma of their experience is reduced and access to social support and services is increased.

Community relations with service planners

Spergel (1976) and Warren (1978) attribute the success or failure of community care facilities largely to the extent and nature of relationships between planners and the people in the neighbourhood. Hasenfeld and Tropman (1979) suggest that the importance of these ties lies in the subsequent ability of the organisation to 'read' its environment and utilise its resources. Empey and Lubeck (1971) reported that projects with sponsers who were well known and respected in that area were more easily accepted than those projects that were equally well run, but with no existing ties in the locality. These relationships are however, fragile and can be soured by critical incidents which reflect badly on the project. Sundeen and Fiske (1982) describe the escalating opposition that was mounted when the local community heard that tenants had been evicted by the owner of the building leased for a new project. Although the home had been about to open, the local population now had an acceptable basis for their opposition (it is more respectable to oppose a project on honourable grounds than to publicly acknowledge negative feelings about clients) and eventually forced the programme to withdraw.

Course of locational conflict

Dear (1976 and 1992) describes the three stage cycle that community siting conflicts usually follow:

Youth:

When news of the proposed facility breaks opposition tends to comprise a small vocal group who live very close to the planned development. NIMBY sentiments are usually expressed in blunt, often irrational and reactionary way.

Maturity:

As the opposition becomes more established the debate moves away from private complaints into a public forum and rhetoric of both parties becomes more rational and 'objective'. Views of the local population are expressed in more altruistic terms and numbers grow as weaker members of the community get drawn into the debate.

Old age:

The period of conflict resolution is often long, drawn out and sometimes inconclusive. Those with most persistence and stamina usually achieve their goals. Typically, some kind of arbitration process is introduced in this stage with both sides making concessions. If positions become sufficiently entrenched a stalemate will ensue - usually ending with the proposed project being withdrawn.

Although it is possible to describe the nature of community opposition to local mental health facilities, to understand this opposition and find ways of overcoming it, it is useful to consider locally unwanted landuses more generally. There is increasing research concerned with the siting of unwanted facilities and ways of overcoming local resistance which has direct relevance and applicability to the siting of mental health facilities.

FACILITY SITING CONFLICTS IN GENERAL

Locally unwanted land uses

Facility siting conflicts have become a serious problem in the implementation of public services policy. Public opposition and protest have halted the siting of locally unwanted land uses (characterised as LULUs by Popper (1987) throughout the US, Russia and Europe. Examples include the construction of nuclear power generators and wind turbine farms (Bosley and Bosley 1988); the siting of waste disposal sites (Gendler 1984; Schneider 1991), roads and railways (Wolsink 1994); the development of shelters for the homeless (Roberts 1991; Gallagher 1992), ex-offenders and substance abusers (Fattah, 1984); facilities for people with AIDS (Bean *et al*, 1989), mental health problems (Dincin 1993) and learning disabilities (Green *et al* 1987).

Although there is evidence that community opposition to LULUs activity has existed over several centuries (Dear, 1992; Lake, 1993), it appears to be more successful in hindering the development of unwanted facilities at the present time (Van Horn, 1988; Popper, 1992). This has to be seen within the current social context which is marked by political emphasis on privatisation and private ownership; extensive de-institutionalisation of people with mental health problems and people with learning disability; reduced public housing; increased levels of unemployment; world-wide recession; the nation's wealth lying in fewer hands resulting in wider discrepancy between the 'haves' and the 'have-nots'; and, perhaps as a result of this social structure, a culture marked by self-absorption and loss of community (as indicated by the 'Me-decade' label accorded the 1980s).

Perhaps it is not surprising that in this context, many people are worried about perceived threats to the value of their property or personal security, but the net result for the disabled and disadvantaged is not only increased material hardship, but diminished public sympathy at a local level (Glass, 1989; Dear and Gleeson, 1991; Dincin, 1993; Grassroots, 1994).

'NIMBYism'

Community opposition is generally characterised as the 'Not In My Backyard' (NIMBY) phenomenon (Heimann, 1990; Wolsink, 1994; Kartez 1989; Dear, 1992; Armour, 1993; Lake, 1993; Weisberg, 1993; Gleeson and Memon, 1994), but there is little clarity or consistency in the definition of this term. It generally refers to the protectionist attitudes and oppositional tactics of community groups facing an unwelcome development in their neighbourhood. But the underlying assumptions of NIMBYism are that facilities are needed for the greater social good and that selfish, local parochialism prevents realisation of that societal good (Wolsink, 1994). Indeed, the projects involved are generally seen to represent 'higher' interests than those of the local population because they are defended by national or local authorities who are usually invested with more power. Gleeson and Memon (1994) develop this argument in their suggestion that facility siting constitutes a political-administrative response to economic crisis that minimises the costs to capital and concentrates costs on communities. Not only is it easier to privilege capital interests than community interests, but the state is dependent on capital growth, whereas it probably can withstand the temporary and localised unpopularity of the 'NIMBYs'.

Lake (1993) suggests that to label community opposition as NIMBYism - and thus label it as local territorialism - distracts attention from major social concerns and it is easier for those in power to criticise NIMBYs as irrational than to ameliorate these concerns at source (for example to blame NIMBYs for their opposition to homeless shelters rather than initiate a new housing program). The selfish parochialism of NIMBYs is frequently demonstrated by those in power by the persuasive rhetoric that 'everyone knows these facilities are in the best interests of the population as a whole'. But as Kartez (1989) asserts, this is a method used by planners and developers to persuade the public of their cause: the public's choices are distorted when value assertions hide under the factual conclusions presented by the experts.

There are evidently large numbers of people who agree with the need for a facility but do not want it in their own locality, but the supposedly selfish attitudes of local populations in resisting a measure may represent far more constructive intentions than are usually attributed to them. For example, opposition may reflect a general concern about such a development wherever it might be (as in the case of nuclear power, when the majority of campaigners are not from the local area (Kates *et al.* 1985). Kartez

(1989) points out the benefits of this sort of action in ensuring balanced societal evolution and survival of social choices.

Alternatively, NIMBY attitudes may reflect healthy concern and interest in being involved in development of the project, or may reflect rejection of the particular plans put forward but not of the idea as a whole (Wolsink, 1994). To consider all community opposition in totally negative terms is to miss the opportunity to work with people such as this who can make valuable suggestions to improve the proposed plans. Segal *et al.* (1980) suggest that although extreme negative reaction does hinder the social integration of community care residents, a moderate degree of adverse reaction seems to promote it.

Explaining NIMBYism

On the premise that to overcome opposition to LULUs, 'rational arguments for irrational audiences' are needed, Kartez (1989) suggests three rival theoretical explanations for NIMBYism: heuristic judgement biases and preferences, schematic thinking and preferences, and the cultural theory of preference. Each of these theories suggests a different way of working with the public to reach a consensus. These are summarised in Table 2.

The heuristic explanation

The heuristic explanation assumes that most untrained people have similar judgement biases, which are significantly influenced by the way in which information is presented. This is based on Tversky and Kahneman's 'prospect theory' (cited in Kartez, 1989) which has been used in very large population experiments to demonstrate that when given exactly equivalent choices, subjects' preferences and judgements depend upon whether they perceive that they are gambling on an endowment that they already have (in which case they will oppose the risk), or on a possibility to improve conditions which otherwise look as though they will constitute a loss (in which case risk taking behaviour will be evoked). This calls for efforts to educate the public in their own biases in judgement by presenting clear comprehensible information. Not only is it expensive to de-bias the public because it is essential that they understand and believe the information given, but it depends upon the agency or public institutions to decide upon

Table 2: Rival explanations for social judgement bias and their implications (Kartez, 1989)

	Heuristics	*Schematics*	*Cultural*
Sources	cognitive psychology	social psychology	anthropology political science
Manipulative treatment of public judgement	train public to de-bias to planners' view; frame information to get desired answers	shape judgements through symbolic associations social interaction.	maintain status quo in name of diversity: 'false promise'
Liberating treatment of public judgment	acknowledge fears prospect costs.	encourage interaction between people with different schemas.	maintain a pluralistic system of biases that balance in the long run.

the rational or unbiased version - an insight which can be used to deceive the public and deflect opposition rather than to identify legitimate public fears.

The cultural theory of preferences

The cultural theory views all information-processing explanations for public risk judgement bias as superficial. Instead differences in biases are seen to reflect beliefs about how to achieve the best life. In many ways these directly reflect different political cultures. Cultural theorists do not advocate training or de-biasing of the public. They hold that the competition between people who have different beliefs ultimately leads to an evolutionary balance based on diversity and flexibility and prevents excesses and mistakes. Although theoretically this is an elegant solution, it ensures incremental maintenance of the status quo with the survival of social choices through conflict rather than guidance.

Schematic thinking

Rather than assuming that biases are uniform, schematic theories recognise that individuals' experiences, training, relationships and social environment are factors in the construction of schemas which are used to test against new information and judgements made about the way it fits with existing schemas. Thus people draw inferences and make decisions based on sketchy information by drawing on internally consistent, but externally inconsistent relationships. Schemas can therefore account for rigid views, or discrepancies between the conclusions drawn by different people. Schematic theories call for reciprocal dialogue between parties to learn from one another and explain the thinking behind judgements; face to face interaction is essential. Increasingly siting conflicts are being resolved through means that acknowledge the different schema of different individuals, validating and acknowledging individuals' fears, recognising that biases will differ according to individuals' experiences, social context and role. This is explored further in the following section in relation to overcoming specific opposition to community mental health facilities.

IMPROVING ATTITUDES TOWARDS COMMUNITY MENTAL HEALTH FACILITIES

High profile vs low profile approaches

In deciding how best to approach the community, Dear (1990) has suggested that planners must choose between a high profile collaborative approach (implying communication and cooperation between host community and project planners), and a low profile, autonomous approach (acting independently of the host community). Collaboration and the development of community relations have been prioritised over the past ten years, but Dear (1992) has more recently observed a new trend towards aggressive autonomy with planners granting most prominence to the civil rights of the clients and correspondingly less importance to the local community opponents. This action is bolstered by legislation which is being introduced to thwart the power of neighbourhood opposition in the US and Europe. However, in the UK the level of opposition appears to be rising and some sort of interaction with the local community is often a necessary part of setting up new facilities in the community.

There is no consensus about the most effective way of managing local opposition but a number of different strategies are available and these need to be selected with the particular characteristics of the facility, the neighbourhood and the clients' needs and views in mind. Although the development of positive relations within a particular community will reduce the stigma of mental illness for some of the people in that locality, broader approaches need to be developed to increase general acceptance of people with mental health problems and reduce the likelihood of opposition arising. At the end of this section various strategies are suggested to break down the existing barriers between local populations and people with mental health problems.

Basic considerations

An essential consideration of planners must be legal requirements and regulations for fire, parking, and the type of landuse. If local people opposing the project discover a breach in regulations this will give them legitimate grounds to express their concern about the safety of the project and the reliability of the operators.

There are clear indications about the type of facility that evokes most opposition (Dear, 1992) which must be taken into account in the design of the facility (e.g. unobtrusive

appearance, with inner courtyards and gardens for users, unobtrusive parking, subtle signposting, and complementary facade).

The same literature is useful in predicting the type of likely response: a large residential facility for offenders cited in a suburban area is likely to cause maximum conflict whereas a small day centre which can be used by the local population may be accepted and even welcomed by the local community.

Information and consultation

Most accounts of siting community mental health facilities describe a high profile approach in which various means are used to increase the public's awareness of the planned project and the clients. Educational leaflets, advertisements and radio programmes offer an indirect and general strategy to let the local population know about a new project, the principles and values of the organisation, the care that will be offered project users, the role of the local community. This is likely to be more effective if it is organised through a local advocacy group with local ties and respect as well as expertise and experience, but it gives no opportunity for feedback and may be seen as presenting a biased view of the project - of trying to win the community round. Alternatively public meetings offer direct contact between project staff and the public, but these are unanimously disliked by those with practical experience of them (Dear, 1992; SAMH, 1992; MACA, 1994). They become a platform for speakers (whether they be for or against a facility) to overstate their case and although they may gain the support of weaker people from the community, they are more likely to alienate the opposition. At least two different studies have reported that this sort of high profile approach has been found to be significantly more likely to encounter opposition than just moving into the facility and waiting for people to find out (Sigelman, 1976; Wenocur and Belcher, 1990).

Since neighbours would not be informed about a large family moving into their street, it goes against the whole theory of normalisation to inform neighbours about the use of a house for people with mental health problems. But as neighbours can be helpful and constructive where they are involved (Segal *et al.* 1982) it is not always clear whether it is best to inform and consult them from the outset, or to respond only if opposition arises.

The practical experience of MACA and SAMH suggests that informing the local population of a proposed project immediately raises anxiety and indicates cause for concern:

> *'you are saying there is something special about the people moving in, there is something to be worried about, they are in some way different and there will be problems. You are reinforcing and rewarding prejudice, not counteracting it'.* (SAMH, 1992, p10).

Although it might be theoretically preferable not to inform the local population of a planned project, SAMH (1992) found that some people who find out about the project themselves are more oppositional than those who had been given information about it. The general consensus of the SAMH report was that if educating the local population made life easier for people using the facility then it should be done. By contrast, Bynon (1994) found that the strategy evoking least conflict in the siting of MACA houses was a low profile, no information approach, followed by direct and personal contact - in their own home- with people who complained. She emphasises the need for a realistic and honest assessment of the effect of the facility on the neighbourhood, with particular attention to the supervision and care that clients will receive.

Overall, the appropriateness of an approach depends upon the size, function and implications of the proposed facility. The low profile approach advocated above is, however, less appropriate in the case of large, obtrusive facilities with residents who are likely to be arouse more fear and more resentment. In this situation it might be useful to set up a Community Advisory Board before opposition emerges (Dear, 1992). Prominent local people should be represented on the board so that the views - and support - of local people can be gained. This board can serve to legitimise the new service, incorporate advocacy skills and defuse opposition by working together to reach a consensus.

Resolving conflicts

Although these strategies may be useful in promoting effective community relationships opposition may still occur. Some neighbourhoods will be unwilling to consider the siting of a facility in their midst, and will thwart the best made plans to work with them towards a positive consensus. In this situation, planners of mental health facilities can learn

from the strategies that have been developed to resolve conflicts in the siting of other LULUs.

In a detailed monograph of her experience in resolving disputes related to the siting of a radioactive waste facility, Armour (1991) describes the development of an effective negotiation process. This draws on the experience of assisted dispute resolution (ADR) reported by Susskind and Weinstein (1981), Susskind (1981) and Susskind and Cruikshank (1987).

Armour argues that the first step in this process involves a different conceptualisation of the problem. Siting conflicts should not be seen as resulting from the unreasonable and selfish attitudes of the local population, but as a real reflection of concerns about health, safety, quality of life, political interests, rights and moral issues. Where individuals concerned perceive that these concerns have not been properly addressed in the assessment of locational options and programme design, then conflicts are likely to emerge. The aim of the planners should therefore not be merely 'to gain public acceptance' but to 'achieve social consensus' and effort needs to be directed towards working 'with' rather than 'against'. There is a need to break out of adversarial approaches towards cooperation.

The approach that is advocated by these commentators draws on schematic principles in recognising that the public and the project planners have different interests and biases (Susskind and Weinstein, 1981; Susskind, 1981; Susskind and Cruikshank, 1987; Armour, 1991). Independent, impartial facilitators or mediators are brought in with the aim of acknowledging these differences rather than coercing change, and finding 'trades' that can serve both parties interests. Thus debates tend to focus on the alternatives that might be possible, the validity of the information presented and how it can be used to assess the advantages and disadvantages of planned projects, and creating opportunities for full participation of the public by deciding their role in the process and their access to information and funding.

The advantages of bringing in mediators to resolve disputes appear to lie not only in the possibility of resolving the immediate problem, but in setting up structures for improving relationships. Thus a prospective plan might be negotiated to deal with uncertainties and monitor each others' interests.

Although there is no literature available on the use of this strategy in the siting of community mental health facilities, it would appear to have direct relevance in situations where an impasse has been reached. It cannot be denied that the location of certain mental health facilities in a locality might be a cause for concern and fear, particularly if they are not providing a service to people from that neighbourhood, and there exist no local community ties. However, a situation which allows both planners and the local population to become more knowledgeable about each others' beliefs, perceptions and goals is likely to lead to greater understanding of the project, individuals' questions being answered, and the neighbourhood's conditions of acceptance being clarified and met. If an ongoing basis for communication, involvement and assessment is also achieved, over time this might benefit both clients and local people.

Increasing general community acceptance of new projects

If adequate care is taken to select appropriate clients, provide responsible and responsive care, and accord local people and clients their civil rights, relationships between project operators and their users are likely to improve. This will serve to reduce the stigma of mental illness within that area and may increase tolerance, but this should not be exploited with the effect of further ghettoisation of urban areas. It is essential that attempts are made to improve tolerance not only within local populations but also within the total population. This might be achieved through a broad based educational and awareness raising strategy which is properly funded and prioritised by purchasers of health and social care.

Fattah (1984) describes an overall approach to increasing the acceptance of the community at large by: i) promoting an understanding of diversity as a manifestation of the enormous variety that exists within the human race; ii) dissipating the myth of the criminal (or mad) 'type'. Media reports and empirical research (Cumming and Cumming, 1957) are testament to the public's general belief that mental illness is not on the same continuum as mental health; iii) alleviating public anxiety and fear through the proper treatment and care of those who do present a risk of danger (Monahan, 1992), and presenting figures which indicate the risk posed by people with mental health problems as compared with the general population. Working with the media to portray more accurate and balanced reports would greatly aid this process (Mayer and Barry, 1992); iv) Educating the public about the nature of mental health problems through long term projects; iv) promoting integration of clients using new facilities rather than

segregation in particular areas and specific services. This would allow more personal contact with people who have ongoing mental health problems - knowing them as people with their own problems of living - not merely the problems they are perceived to be causing others in the neighbourhood.

SAMH (1992) suggests that barriers could be broken down through the better education of General Practitioners who they found to be among those opposing new projects in their locality. They also suggest the importance of supporting anti-discriminatory legislation to allow the mental health movement to be less defensive in justifying what it is doing and more able to call for fair treatment as a matter of right. In order to protect clients in areas where hostility exists, SAMH (1992) advocates putting pressure on public sector landlords to implement clear equal opportunity and anti-harrassment policies, and encouraging the voluntary sector to strengthen its policies to deal with alleged harrassment from inside and outside the project.

SUMMARY AND RECOMMENDATIONS

1. Attitudes towards people with mental health problems

1.1 Most research has been conducted in the US, but there has been more recent interest in factors effecting attitudes towards people with mental health problems in Europe and the UK.

1.2 Findings are complex and contradictory but more tolerance has been found to be associated with: acquaintance with mental health problems; younger age groups; higher socio-economic status; and higher education, whereas negative reactions are precipitated by evidence of bizarre, disruptive and dangerous behaviour, and a psychotic diagnosis.

1.3 Over the past two decades surveys have demonstrated increasing acceptance and tolerance of people with mental health problems, but there is evidence that people are less positive about the prospect of living in the close neighbourhood of people with mental health problems.

2. Attitudes towards mental health facilities

2.1 No empirical work appears to have been undertaken in the UK looking particularly at local opposition to community mental health facilities. Most research has been undertaken in Canada and the U.S, but there is no evidence of research into attitudes towards medium or interim secure units, and no evidence or research into rural siting of community mental health facilities.

2.2 No systematic research has been conducted to assess the extent of opposition towards mental health facilities but practical experience of agencies within the UK suggests that local opposition has increased over the last three years and is now threatening community facility siting.

2.3 Local opposition towards the siting of a new facility appears to be based on concerns about: effect on property values, threat to neighbourhood amenities, and

fears about personal security. There is very little evidence to substantiate these concerns.

2.4 The likelihood of local opposition can be predicted to some extent by consideration of: client characteristics, type, size and function of facility, reputation of the agency planning the project, and the nature of the host community. In effect, opposition is most likely to occur in relation to a large, obtrusive facility for the care of offenders who do not necessarily come from the local area.

2.5 Opposition is likely to be most vehement if the agency has no local ties or relationships with community leaders, and if the host community is a conservative, well integrated, stable, middle class, home owning suburban population.

3. Facility siting conflicts in general

3.1 Public opposition to locally unwanted landuses has been the subject of extensive and increasing research, legislation and negotiation activity. As such it offers some insight into the theoretical underpinnings of opposition towards community mental health facilities.

3.2 These imply particular methods of ameliorating public opposition towards local communities which can be applied to conflicts arising in relation to the siting of community mental health facilities.

4. Improving attitudes towards community mental health facilities

4.1 As a basic consideration all planners should pay attention to legal requirements and legislation.

4.2 There are conflicting views about the value of collaborative vs autonomous approaches: a high profile, collaborative approach which involves and informs the local population might be more appropriate for a large, obtrusive facility; a low profile, autonomous approach for a small group home or day facility.

4.3 If a high profile approach is to be used, public education is most effective if run by a local advocacy group.

4.4 Where research suggests opposition is likely to occur, it may be useful to set up a community advisory board before any concerns are raised and develop positive relationships with respected people or leaders within the local community.

4.5 If conflict arises it may be useful to bring in independent arbitrators to facilitate a consensual plan of action which recognises the concerns and agenda of both parties.

4.6 More positive local attitudes towards community mental health facilities may be encouraged by broader initiatives to educate the public through funded programmes.

4.7 Local policies to deal with harrassment and to ensure equal opportunities in mental health services and homes provided by local authorities, health services and voluntary agencies might improve the experiences of individual clients. Agencies providing services for people with mental health problems could work more actively to positively influence the media presentation of mental health, and to support anti-discriminatory legislation.

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