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/ A STUDY OF COMMUNITY ATTITUDES TOWARD  
OUT-PATIENT MENTAL HEALTH FACILITIES /

by

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B.S., College of Agriculture, 1981

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A MASTER'S REPORT

submitted in partial fulfillment of the  
requirements for the degree

MASTER OF REGIONAL AND COMMUNITY PLANNING

Department of Regional and Community Planning

KANSAS STATE UNIVERSITY

Manhattan, Kansas

1986

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# CHAPTER I

## INTRODUCTION

### PURPOSE OF THE STUDY

Increasing numbers of the mentally ill are being moved out of large institutional treatment settings to receive care within the community (1). The community mental health movement is seeking to resocialize the mentally ill by providing care within a variety of smaller-scale community-based facilities such as group homes, social-therapeutic centers, and outpatient clinics. By providing care within the context of normalized community environments, it is felt that the successful reintegration of the mentally ill into society will be expedited.

The purpose of this research is to examine the outpatient community-based facility and to study the community attitudes toward these facilities. This complex issue of community attitudes toward these community-based mental health facilities is an important factor in planning. An ability to predict the likely reactions of local residents is valuable in the interests of seeking to maximize benefits for clients and to minimize conflict over planning decisions.

This study is also designed to:

1. Show the effect of mental health facilities on the community through documented studies;
2. Show how community-based facilities can be handled more effectively to reduce exclusionary zoning; and,

3. Identify means of improving acceptance toward mental health facilities.

The study is based mainly on the research of secondary sources of information from books, articles, journals and periodicals. The author has attempted to obtain the most recent information by interlibrary loan, and by purchasing newly published books.

### Definitions

1. The outpatient psychiatric clinic (2).

Numerically, this is the largest of community mental health facilities. It is defined by the United States Public Service as an unit that provides outpatient mental health services and has a position for a psychiatrist who has regularly scheduled hours in the clinic and who assumes medical responsibility for all patients. A majority of the clinics are independent, non-hospital-connected units.

The chief function is to provide services that make it possible for the patient to remain in the community while receiving care on outpatient basis. Clinic treatment is most often individual psychotherapy, group therapy, drug therapy, and shock therapy. Clinics that are highly specialized are usually found in large metropolitan areas. The use of home visiting and treatment by clinic teams in the United States is growing.

2. Inpatient (e.g., halfway house, drug abuse clinics, alcohol treatment centers) (3).

A facility serving temporary residents who have generally been institutionalized and releases, such as criminal offenders, the mentally ill, alcoholics, drug abusers, or delinquents, who receive help in functioning in a normal society through shelter, supervision, and rehabilitation services. A group home or boarding home capable of serving more than six residents would be considered a halfway house.

#### THE HISTORY OF MENTAL HEALTH FACILITIES

Care of the mentally ill historically has been characterized not so much as a process of treatment and rehabilitation as it has been a process of social isolation and exclusion (4). Despite the use of numerous treatment methods and the best of intentions, mental illness has often been regarded not only as a medical problem but also as a social problem to be controlled most effectively by the exclusion and isolation of the parties in question. The purpose of such practices has always been to protect society from the individual despite certain pretenses of treatment. Although the existence of mental illness has long been recognized, a persistent problem has concerned the definition of what constitutes mental illness. Criteria for the definition of mental illness has traditionally included the individual's manifest behavior, the frequency and duration of his or her deviant behavior,

and the degree of danger posed to other members of society; another important consideration involves the set of social standards or values which define "normal" behavior from which the actions of the mentally ill deviate (5). Whether or not a person is considered mad depends upon the degree of behavioral disturbance and the attitudes of society toward deviant behavior. One of the most important contributions of this act of labelling has been to focus attention on the way labelling places the act or in circumstances which make it harder for the mentally ill to continue the normal routines of everyday life and thus provoke him to "abnormal" actions (6). Thus, changes in the definition of mental illness and preferred methods for its treatment have reflected not only advances in medical knowledge and treatment techniques but also, and perhaps more significantly, changes in social and attitudinal beliefs and prejudices.

#### The Community Mental Health Movement

Until recently the hospital was the major resource for treating the mentally ill. Usually, mental patients were placed in special state institutions which offered individualized care. By the late 19th or early 20th century, they began to increase in size in order to accommodate increased numbers of mental patients.

By 1955, there were nearly 560,000 resident patients in public mental hospitals (7). The foundation for the community mental health movement was laid with two major developments in the treatment of mental illness. The first development, the use of chemotherapy, proved to be a significant factor in reducing the length of hospital stays.



In addition to being an effective treatment for the symptoms of mental illness, the use of tranquilizing agents brought previously unmanageable psychotic patients under control. The second development was the introduction of new psychiatric clinics. By 1964, over 1,600 community-based outpatient clinics were in existence and the trend was away from long-term treatment in institutions and toward care in the community (8).

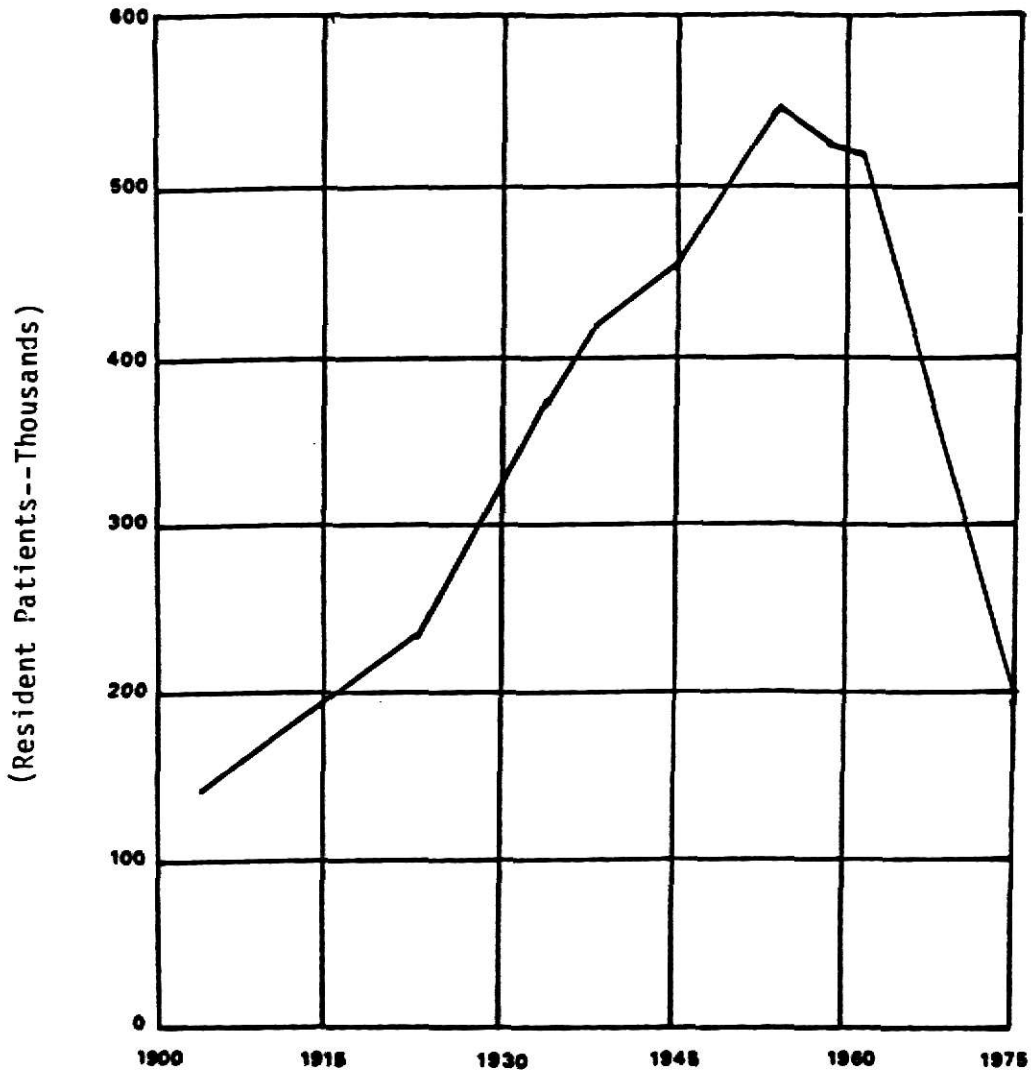
In 1955, the Joint Congressional Commission on Mental Illness and Health was established; its report, in 1961, advocated deinstitutionalization of the large state mental hospitals. It was felt that such institutions "served to isolate the patient from society, to retard living skills and to induce a level of disability and dependence over and above that arising from the patient's condition (9). From this report of the Joint Commission, the 1963 Community Mental Health Centers (C M H C) Act (P.L. 88-164) was created.

Five essential service elements must be encompassed by the CMHC program proposed by the Joint Commission. The essential elements of a CMHC program are inpatient services; outpatient services; partial hospitalization services; and mental health consultation and education services to community agencies and professionals (10).

This concept of "community mental health" implied a dual promise: treatment and rehabilitation of the severely mentally ill within the community and the promotion of mental health generally (11). The first promise was to be fulfilled by the development of an extensive support system for the mentally ill, based on community mental health centers

and offering comprehensive and coordinated treatment and rehabilitation services. These new and less restrictive services were to take over the traditional functions of large custodial institutions in caring for chronically disturbed individuals. The second aim of the program, the broad improvement of the nation's mental health status, was to be accomplished by preventive programs originating in the mental health centers.

The community mental health movement has had a drastic effect upon the pattern of mental health care delivery in the United States. Between 1955 and 1975, the number of patients resident in mental hospitals in the United States decreased 65% from 559,000 to 193,000 (Graph 1). Over the period 1955 to 1973, the percentage of total patient episodes accounted for by state mental hospitals dropped from 40% to 12% while the share represented by outpatient clinics rose from 42% to 65% (Table 1) (12). The general profile of mental health care delivery in the United States following deinstitutionalization legislation can be characterized by an increased volume of service utilization, shorter hospital stays, and a major shift in treatment settings towards community-based care away from large state mental hospitals.

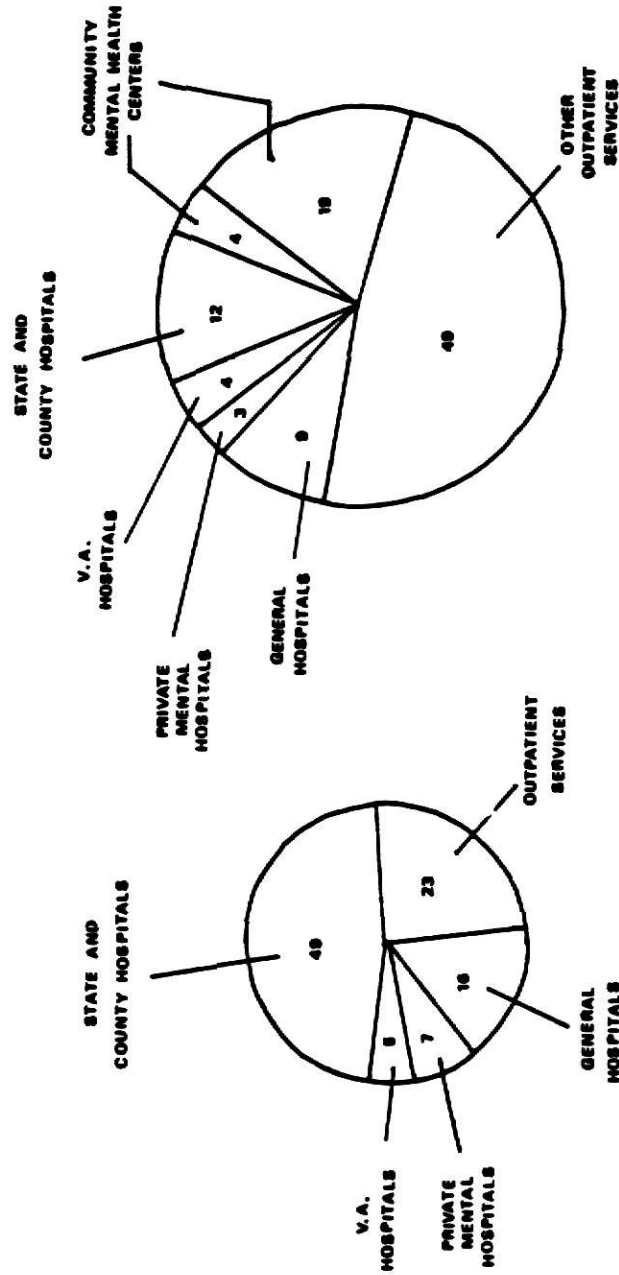


Graph 1: Inpatient Population of state and county mental hospitals rose steadily from the turn of the century until 1955, since when it has decreased sharply.

Source: Bassuk, Ellen L., Deinstitutionalization and Mental Health Services, 1978.

Table 1

Shift to Outpatient Services



Shift to Outpatient Services is illustrated by the two pie charts. The numbers give the percent of total episodes accounted for in 1955 and 1973 by various facilities offering either inpatient or outpatient services. The community mental health centers that have been established since 1963 account for much of the outpatient increase, but other outpatient facilities have also expanded.

Source: Bassuk, Ellen L., Deinstitutionalization and Mental Health Services, 1978.

**CHAPTER II**  
**COMMUNITY RESPONSE TO MENTAL HEALTH FACILITIES**

**PHYSICAL AND SOCIAL CHARACTERISTICS**

The community in general, with the introduction of the CMHC, are better informed about mental illness than in the 40's and 50's but still widely consider it as "noxious." Consequently, mental health care planners have not anticipated adequately the degree of community opposition to facility locations in residential neighborhoods.

There are two main factors that influence the communities' response to mental health facilities; these are the physical and social characteristics of the community (13). As far as physical structure is concerned, there appears to be little variation between its effect upon community mental health facilities and urban public facilities in general.

Land-use mix and physical quality of the neighborhood are perhaps especially important. Resistance to facilities is likely to be lower in areas of mixed land-use, with a high proportion of rental or commercial properties, and in a comparatively poor state of physical repair. Two factors combine to reduce opposition in such areas. First, a facility could remain relatively invisible given the existing mixture of land-uses. Second, the residents, especially if they are tenants, may have little incentive to protect the quality of a neighborhood which is already deteriorating. In contrast, in suburban subdivisions with a large number of owner-occupied single-family

housing, the introduction of a facility is more likely to be highly visible and to be perceived as a threat to neighborhood quality and to property values.

The social characteristics of a neighborhood also affect response to community mental health facilities in residential neighborhoods. Trute and Segal (14) observed that the highest levels of integration were found in communities with low levels of social cohesion. The lowest integration levels were observed in highly cohesive neighborhoods, predominantly suburban communities with high proportions of traditional nuclear families which were homogeneous with respect to class, education, and race. It was found that although upper class neighborhoods exhibited more tolerant attitudes towards the mentally ill, they contained disproportionately fewer facilities than facility-saturated lower class neighborhoods. Although this pattern is partially attributable to the greater availability of less expensive convertible housing in lower class neighborhoods, it is also indicative of the greater degree of political "clout" found in upper class neighborhoods, and their greater ability to deflect locational decisions (Figure 1).

These results can be compared with the work of Taylor and Hall (15). Their findings show that there are five social characteristics of a neighborhood: transience, scarcity of children, economic status, ethnic status, and sex ratio.

Neighborhood transience had a negative sign, indicating that high positive scores on this characteristic were associated with low levels

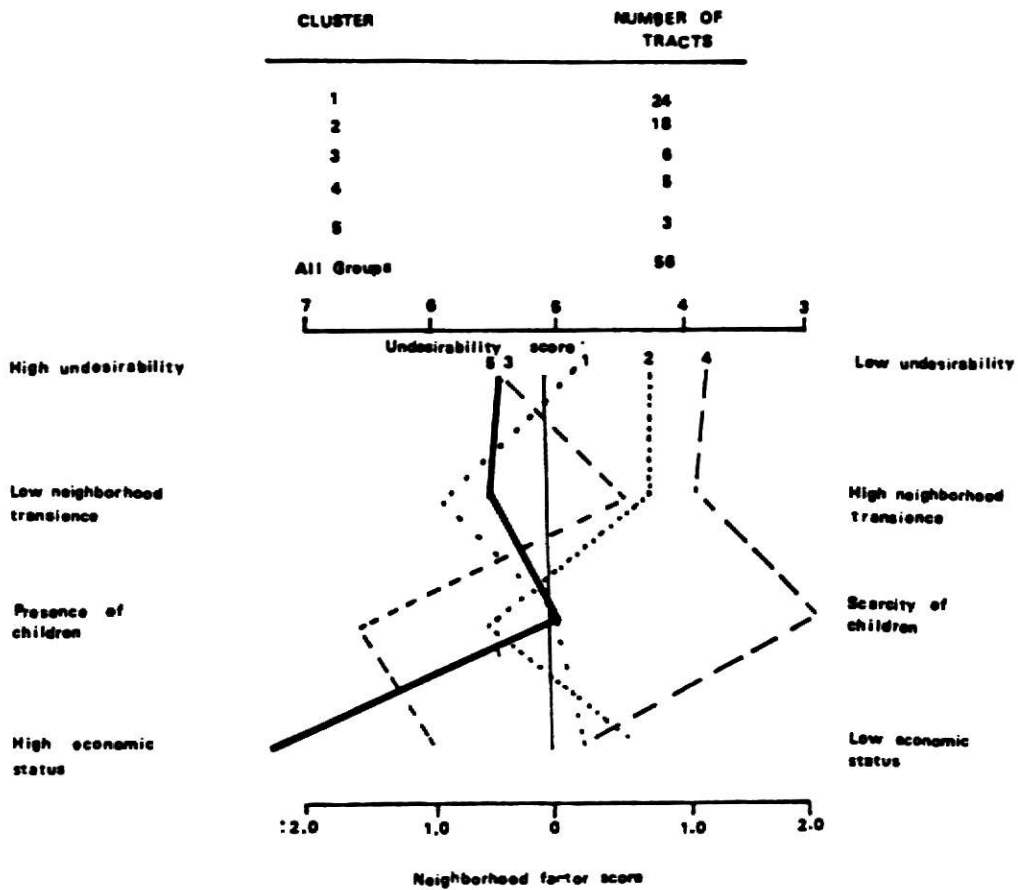


Figure 1: Profile for Major Census Tract Clusters

Source: Taylor, S.M., Predicting Community Reaction to Mental Health Facilities, 1984.

of opposition to facilities. It was found that high positive scores characterized neighborhoods with high percentages of migrants, one-person households, unemployed, single-persons, and high population density. Conversely, strong opposition to facilities was correlated with low levels of neighborhood transience defined by high percentages of detached dwellings, owner-occupiers, children over age 18, and high average incomes. The correspondence between transience and the concept of neighborhood cohesion, identified by Segal (1976) (16) was strongly confirmed by the findings that socially cohesive neighborhoods (i.e., low neighborhood transience) are the least accepting of the mentally ill and the facilities that serve them, and that socially fragmented neighborhoods (i.e., high-neighborhood transience) are the most accepting.

Scarcity of children had a negative sign also, showing that neighborhoods with a predominance of families with children report stronger opposition to facilities than do neighborhoods with singles and one-person households. The presence of children in the neighborhood strengthens opposition toward facilities, probably because of its effect on fears for personal safety.

Economic status had a positive sign, indicating that level of opposition to facilities was directly related to the socioeconomic status of the neighborhood. The higher the status the more these neighborhoods resisted threats to the quality and to the value of their economic and social advantage.

The ethnic status and sex ratio were too weak to be interpreted.



But overall, the results described the general characteristic profiles of accepting and rejecting neighborhoods. Accepting neighborhoods were those with relatively transient populations, high population density, mixed housing stock, few family-based households, and lower income. Rejecting neighborhoods were characterized by stable populations, low population density, predominantly single-family housing, a high proportion of families (and children), and higher income levels.

#### EXTERNAL FACTORS EFFECTING RESPONSE

The existence of a range of external effects in association with community mental health facilities has been confirmed (17). Residents seem to fear the negative effect of such facilities on property values, traffic volumes, and residential satisfaction. However, there is a strongly 'neutral' core of respondents, who essentially believe that such facilities have no impact on local neighborhoods. Respondents who claim to be aware of a local mental health facility are relatively more tolerant in their estimation of the neighborhood impact of mental health facilities, and even appear to anticipate certain positive neighborhood advantages of a facility's introduction.

As proximity to a potential facility increases, so does the undesirability of that facility. The most negative responses tend to occur within one block of a facility location, but beyond a distance of six blocks a more tolerant attitude is evidenced. Both awareness of a facility and type of local facility appear to have some effect on the

results. The mental health facility appears to be a classic 'noxious' facility, in that it is generally regarded as a necessary service, but it is least welcomed by residents closest to a potential site.

Although communities realize that the facilities are needed, the "not on my street, not in my neighborhood" attitude is prevalent. In 1981, a major study on community attitudes toward mental health care was published (18), which exhibited an interesting characteristic. An unexpectedly small number of respondents in those neighborhoods which had a mental health facility were aware of its existence.

Similar results were found in a Green Bay, Wisconsin study (19). The study asked people living within one block, two block, and three block distances of a mental health facility a series of questions concerning the facility. On the average, only half of the residents living on the same block as the facility knew of its existence. In the second block this dropped only slightly to 46%. But by the third block only 30% of the people knew of its existence.

Through an examination of the effect of mental health facilities upon local property values, there was found no evidence that the volume of property sales was either greater or lesser in facility than in control areas before, during, or after facility introduction. It could not be concluded that the property market in the facility areas had 'bottomed out' because of lack of demand, as there was no evidence of decline in sales prices in these areas. In facility areas, house prices tended to increase at a comparable rate to those in the control areas. The most important factors influencing house prices were the

typical features of the housing units themselves, particularly the number of rooms. Other neighborhood-related characteristics (city or suburban location, land-use mix) had only a minor effect upon property values. It can be concluded that the introduction of a mental health facility has no conclusive effect on neighborhood property values (20).

#### ATTITUDES TOWARD MENTAL ILLNESS

Research of the mentally ill has fallen into two groups: those supporting the mentally ill; and those rejecting. There has been a general increase in the level of knowledge about mental illness, despite only limited acceptance of the notion that the mentally ill are not unlike other ill individuals (21). Dear and Taylor (22) observe that, "there has been a trend toward greater acceptance of the ex-mental patient but a large social distance is still kept by the public from the ex-mental patient when close interpersonal relationships are involved."

In reviewing the literature on factors influencing attitudes toward the mentally ill, Freeman (23) and MacLean (24) found that younger age groups as well as more highly educated groups tend to exhibit more scientific and enlightened attitudes towards the mentally ill while older and less educated groups tend to be more rejecting and unsympathetic in their attitudes. A study by Lemkau and Crocetti (25) concluded that a greater recognition of mental illness and a greater degree of tolerance in terms of recommended treatment methods is found in higher social status groups. Dear and Taylor (26) observed that a

range of demographic characteristics including age, sex, numbers of school-aged children, education, tenure, church attendance, and familiarity with mental health care, accounted for significant, although low, percentages of variation in attitudes toward the mentally ill.

Another study by Rabkin (27) found that people are now better informed about mental illness and are more willing to accept the widely disseminated message "mental illness is an illness like any other." but still a major portion of the public continues to be frightened by the notion of mental illness although it is becoming less socially acceptable to say so.

Rabkin (28) says there are certain characteristics that are attributed to mental patients. One of the most influential of these is unpredictability. Mental patients are characteristically viewed as unpredictable, impulsive, erratic, and unstable.

A second significant characteristic is dangerousness. It is a common concern and part of the popular stereotype of the mental patient. Dr. Rabkin (29) said that in a 1975 survey of community attitudes conducted in California, only 17 percent of the respondents agreed that mental patients are not dangerous.

A third characteristic is responsibility for their plight. A lot of people feel that if you are blind, it's an act of God, and if you are retarded, that's unfortunate, but if you are mentally ill, you had something to do with that and you are not altogether as acceptable as those who are singled out by nature of some other abstract force.

In summary, the success of community-based programs and individual facilities is contingent to a large extent upon the degree of community integration accorded to facility users. The most successful facilities will be those located in communities which are openly supportive of the objectives of community-based care. Conversely, the least successful facilities will be those located in non-supportive communities, particularly those which actively seek to block the introduction in their neighborhoods.

## CHAPTER III

### ZONING

#### ZONING DEFINED

American courts have defined zoning as a general plan to control and direct the use and development of property in a municipality by dividing it into districts according to the present potential use of the property (Devaney v. Board of Zoning Appeals of the City of New Haven, 45 A.2d 838, Conn. 1946).

#### Legal and Zoning Issues

Few states have established policies or enacted laws covering how community facilities for the mentally disabled should be interpreted for local zoning purposes. The zoning ordinances address the mentally disabled indirectly rather than directly through the broader use of definitions.

Because mental facilities are a relatively new phenomenon, few cities have adequately defined or provided for them in their zoning ordinances. Planners have made few studies of those facilities and are generally unaware of their nature or purpose, the clientele they serve, or their locational needs. Most cities, for lack of an appropriate ordinance, require community mental health facilities to adhere to the regulations governing the hospitals.

Another restrictive zoning mechanism is the requirement that a special- or conditional-use permit be obtained before a community facility can be established (30). Such a requirement often even

applies in multiple-family areas. Since few cities have developed special-use criteria specifically for community facilities, they frequently have to abide by regulations governing other types of facilities, such as hospitals or other similar uses, which are the most approximate categories to community facilities. Consequently, before a special-use permit is granted, the neighbors are generally invited to attend a public hearing. Since granting the permit is discretionary, substantial opposition can block it.

Almost all the statutes contain loopholes by which the community can continue to discriminate against mental health facilities. By allowing the communities to implement a "conditional-use permit" procedure many of the statutes grant the local government broad discretionary powers. The activities of local communities in the last decade demonstrate beyond question that most will use that power to frustrate efforts to establish community facilities.

In the past few years several cities in various parts of the country have rewritten their zoning codes to deal more rationally and consistently with community facilities. All require the granting of a special-use or conditional-use permit before a facility can operate legally. One of these cities is Portland, Oregon and its ordinance requires that, prior to granting a special-use permit, an open neighborhood meeting be held by the applying agency to inform the neighborhood about the proposed facility. Other similar ordinances imply that the neighbors, from a practical standpoint, should be

advised of the planned facility prior to the planning commission hearing on the special-use permit.

The City of Lenexa, Kansas has just completely revised the portion of its zoning ordinance dealing with family and health institutions. Lenexa's definition for an institution is "A facility providing medical, behavioral, psychiatric, social, respite, educational, rehabilitative, or protective services for more than fifteen persons, plus staff. These facilities commonly include hospitals, nursing homes, convalescent centers, penal and correctional facilities, or any use permitted within a residential care facility" (31). This definition was then recently amended by adding as follows:

Residential Care Facility (e.g., group homes, halfway houses, homes for adjustment, rehabilitation centers, foster homes, day care homes, preschools, etc.). A facility generally located in residential environments. These facilities may provide medical, behavioral, psychiatric, social, respite, educational, rehabilitative or protective services for such groups as the developmentally disabled, the physically handicapped, alcoholic and other drug abusers, the aged, prison pre-parolees or other criminal offenders, the homeless, battered wives and children including abused and runaways.

The Lenexa Ordinance also requires a special-use permit before approval of any of the above uses.

The City of Manhattan, Kansas has a different definition that mental health facilities fall under; it is defined as "hospitals and other similar uses." The facility must meet certain zoning criteria,



and is allowed only in certain residential districts. These districts include R-2 (single and two family), R-3 (multiple family), R-4 (general residential), and R-M (multiple residential) and allow up to a four family district. Manhattan requires a conditional-use permit in all their residential zones.

Don McCullough, the Assistant Director of Pawnee Mental Health in Manhattan, Kansas, says the zoning laws are very vague in Manhattan. This holds true for other Kansas cities. The City of Leawood is very similar to Manhattan when designating a definition within which mental health facilities are included. Leawood places their mental health facilities under the definition of "hospitals or penal or correctional institutions; special care facilities for humans." Again, Leawood requires a special-use permit before zoning for a mental health facility.

#### EXCLUSION OF THE MENTALLY ILL

One of the primary goals of the community mental health movement has been to combat exclusion trends. It has stressed that the treatment outside of an institution would help maintain the person's integration in the community or facilitate his reintegration into the community.

The community mental health movement or better yet "deinstitutionalization over the last fifteen years in the United States has had both positive and negative results. The positive results include mental health clients receiving less restrictive care

and training at the community level. Receiving help in communities rather than in large state or private institutions enhances their opportunities for normalization.

On the negative side, some communities have not been receptive to the mentally ill receiving help in their area, and, at times, resistance has prevented local program development. Such resistance occurred with the development of a facility in western Wisconsin.

### Wisconsin Case Study

In Wisconsin, all state grant-in-aid funding for mentally ill is channeled through local Unified Boards (32). In the fall of 1974, several of the Unified Boards of Wisconsin adopted a plan to develop a mental health facility in one of its counties. The Board then instructed the staff of the Mississippi River Human Services Center (MRHSC), a community mental health center, to find a suitable site in the largest town in the county, where the MRHSC operated a mental health facility.

Through various channels the community and the neighbors of the area under consideration were informed of the need for the program and the location of the facility. Shortly thereafter, the executive director of the MRHSC, who had coordinated the planning, left his position. After his departure, the neighbors in the middle-upper class neighborhood circulated a petition against the facility. They protested to the City Council that it would cause traffic problems, the clients would engage in assaultive, sexual or other criminal behavior, and that property values would be lowered.

With no advance public notification, the city council accepted the petition and ruled that no zoning variance for a mental health facility would be made.

Another available area was selected—this time in a middle class section of the town—and an open hearing was set up to discuss the need for the facility. There was much negative response to the proposed facility and the city council again turned the proposal down.

However, within a couple of months a local businessman expressed an interest in providing a house to the mental health corporation. He owned a large older house in a transient, lower to middle class section of town, next to a commercial area. No open hearings were held and the businessman handled the zoning issue on his own. The facility went through without a hitch.

In this study there are strong ideological conflicts between the parties. Since the mental health developers had relatively little ability to influence the city council, the facility would probably not exist if a member of the power structure did not have a vacant house on his hands. Figure 2 delineates groups whose ideologies can effect mental health facilities (33).

Professionals in the mental health field favor the development of facilities (34). They do not generally view the mentally ill as threats or in economic terms. Consumer groups, have a vested interest in securing services for themselves and their family members. The general public seldom views the problems of the mentally ill as their own and thus is generally resistant to change not in its perceived