NEIGHBOURHOOD ATTITUDES TOWARD GROUP HOMES
FOR ADULTS WITH A MENTAL HANDICAP

by

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

in

THE FACULTY OF GRADUATE STUDIES
Department of Educational Psychology and Special Education

We accept this thesis as conforming

to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

October 1991

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Date 28 October 1991
ABSTRACT

This study investigated neighbourhood attitudes toward people with mental handicaps. It examined the public's knowledge about mental handicaps and collected demographic information about the respondents. A total of three hundred households were surveyed, seventy-five in each of four areas in Vancouver, B.C. Each area was divided into immediate, intermediate and distant neighbours, centred around a group home.

The research questions investigated the influence of factual knowledge, proximity and the amount of contact with people who have a mental handicap and demographic factors on neighbours' attitudes towards adults with a mental handicap.

Descriptive statistical and ANOVA procedures were conducted. The results did not produce statistically significant evidence to answer the research questions. However, two moderate trends were detected. Immediate and intermediate proximity groups showed slightly more tolerant attitudes than the distant neighbours. Respondents with higher amounts of contact with people who have mental handicaps scored higher on the attitude scales, but not at statistically significant levels.

There is a discussion of the implications of the study and suggestions for further research.
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ACKNOWLEDGEMENTS

The writer expresses her appreciation to her advisor, Dr. J.D. Willms for his assistance and direction throughout this study. She would also like to thank committee members Dr. Ron Neufeld and Bob Poutt for their advice and support.

The writer would also like to express her gratitude to the G. Allan Roeher Institute for its financial support of this project. She also extends thanks to Stewart Seidel for help in the preparation of this manuscript.
CHAPTER I. INTRODUCTION

The last twenty years has seen a strong movement toward the provision of homes in the community for people with mental handicaps, primarily due to the adoption of the normalization principle in North America. The prevailing philosophy is that all persons, regardless of their handicap, have the right to live in an environment as close as possible to their peers (Baker, Seltzer & Seltzer, 1977). Large, segregated, protective institutional settings, prominent since the turn of the century gradually have been closed.

Neighbourhood group homes have become a typical option in residential services for adults with mental handicaps. The first people to be deinstitutionalized were those with mild and moderate impairments. Over the last five to ten years, this trend has been expanded to include people with severe handicaps in these community settings. Today, this population is considered by professionals to be able to learn many skills, to participate in social activities and thus be able to benefit from integration with the community around them (Switzky & Haywood, 1985).

The force of advocacy and law in the years since the 1960's has brought about concerted efforts to integrate citizens with disabilities into all aspects of society, including areas of residential living, learning and training, and employment. (Halpern, Close & Nelson, 1986, p. vii).

A critical factor influencing the success of community integration is the degree of acceptance of group homes and their residents by neighbours (Berdiansky & Parker, 1976; Conroy & Bradley, 1985; Heal, Sigelman & Switzky, 1978; Kastner, Reppucci & Pezzoli, 1979; Roth & Smith, 1983). Blackard and Barsh (1982) consider that deinstitutionalization, group homes, community-based services and independent living projects all depend on community acceptance and support.

Bank-Mikkelsen (1969) mentions that the creation of positive attitudes toward handicapped people was a primary goal of the normalization movement. Misunderstanding about the nature of disabilities leads to misconceptions and
stereotypes. Community education influences the success or failure of programs (Blackard & Barsh, 1982). Gottlieb (1975) emphasizes this view, stating:

An underlying assumption is that when attitudes toward retarded people are more favorable, more enlightened treatment of them will ensue; when attitudes are not favorable, the retarded will continue to suffer. (p.99).

Since community group homes are important in the continuum of services for individuals with mental handicaps, group home developers should consider spending more time, money and energy to enhance the acceptance of group homes (Holmes, 1979).

Willms (1978) conducted a study on neighbourhood attitudes toward a group home in the Vancouver area. The present study, based on Willms (1978), expanded the scope to include four group homes. It used revised knowledge and attitude questionnaires.

This survey study investigated neighbourhood attitudes toward community integration of adults with mental handicaps in group homes in four residential areas of metropolitan Vancouver. The survey addressed areas of concern previously identified in the literature, and considered them in the Vancouver context. It examined the public’s knowledge of people with mental handicaps and their attitudes toward this group. As well, it collected data on the frequency and nature of contact with this population. It gathered information regarding demographic indices such as occupation, education, length of residence, age, mother tongue and gender.

The study asked the following questions:

1. Does factual knowledge about mental handicaps influence the response of neighbours to group homes?

2. Does closer proximity and increased contact influence the response of neighbours to group homes?

3. What factors contribute to acceptance of group home residents by the surrounding neighbourhoods?
The study had two dependent variables as measured by responses to the survey:

1. Factual knowledge about mental handicaps.
2. Attitudes toward community integration of adults with mental handicaps.

The independent variables considered include the area where the group home is located, the proximity of the respondents in relation to the home, previous contact with people who have a mental handicap and the frequency of this contact, residence ownership, length of residence, socioeconomic status, age, level of education, mother tongue and gender.

The results are useful to administrators and managers in the planning of future group homes. The findings help determine misconceptions, fears and concerns that should be addressed through public awareness and education programs to foster more accepting attitudes.

Significance of the Study

Researchers have, at different times, looked at various aspects of this topic. This study concentrated on the knowledge and attitudes of neighbours and their proximity to group homes. In particular, it updated and furthered Willms's (1978, 1981) study conducted in the Arlington area of Vancouver. It employed updated and revised questionnaires and scales. The present study looked at four group home neighbourhoods and included residents with severe mental handicaps. The larger sample and inclusion of a variety of areas increased the generalizability of the results.

The findings may be useful in the planning of future group homes and in the consideration of public education and awareness programs. The identification of misconceptions, fears and concerns could help delineate areas to be addressed in campaigns aimed at fostering more accepting public attitudes. Information highlighted can help managers of group homes plan preventative measures which
could reduce or eliminate possible misconceptions or misinformation. Findings can aid in the design and implementation of programs to increase public awareness and improve community attitudes concerning the integration of people with mental handicaps.
CHAPTER II. LITERATURE REVIEW

Introduction

Community concern about people with mental handicaps has grown as this population is leaving institutional settings to live in local neighbourhoods. This movement to community-based services gains perspective with an overview of the history of services for the mentally handicapped, and a description of the influence of the normalization principle. Community integration is a part of this principle (Gottlieb, 1975). The acceptance of group homes by the surrounding neighbourhood is crucial to successful integration into the community (Kastner, Reppucci & Pezzoli, 1979). Researchers believe that the public's knowledge about these conditions and its contact with people with mental handicaps influence attitudes towards this group (Conroy & Bradley, 1985; Willms, 1981).

This review of the literature sets the framework for this study and summarizes the history of residential services for people with mental handicaps from the 1800's to the present. The roots and history of community-based services, as well as the development of the normalization principle, is summarized. This is followed by a review of studies specifically concerned with community attitudes toward group homes for people with mental handicaps.

Background

Since the early part of the nineteenth century, residential services for people with mental handicaps have reflected the changing perceptions of this population by professionals and the public at large. Those providing services in the early 1800's regarded the mentally handicapped as developing people, who, through training, would progress and take their place in mainstream society (Langone, 1986;
Pritchard, 1963). In the first half of the 19th century, service providers such as Howe and Seguin felt that through sound educational strategies adaptive and social skills could be taught to enable individuals with mental handicaps to function in society. Consequently, services were available in the community, often in a family setting, and education was considered a right (Howe, 1848). The purpose of institutional care was to train individuals for community life. After life skills training, people went to live with their own families or were provided foster care. This approach was successful but the training methods used at that time worked well with the more "educable" individuals. As more severely handicapped people remained in institutions, the focus there became custodial care, with little, if any, training. (Tari & Fenn, 1988).

At the end of the nineteenth century this attitude shifted to one of pessimism and protectiveness. Segregated, isolated institutions were opened and misconceptions based on fear and misinformation prevailed. Goddard's writing on eugenics and "the hereditary basis of feeblemindedness" influenced the formation of public policies during this period (Goddard, 1916; Smith, 1985).

In the early 1920's there was a philosophical shift, when people with mental handicaps were no longer thought of as evil. Rather, institutions for the handicapped were considered appropriate as a way to remove the burden and disruptive influence from the family. Institutions met the basic needs of the inhabitants, sheltered them from competitive society and relieved the community from the pressure of dealing with these individuals (Gollay, Freedman, Wyngaarden & Kurtz, 1978). Institutions remained and expanded although the rationale for their existence had shifted.

Major changes began to appear with the growth of parent groups in the 1950's. These groups, which gradually grew into more formal associations, lobbied for improved standards, facilities and programs for their mentally handicapped children. These developments coincided with a renewed interest from professionals
who came to realize that people with mental handicaps could, in fact, learn many things previously assumed beyond their capabilities. Knowledge of theories of learning and principles of operant conditioning became more widespread in the field of psychology at this time (Heal, Sigelman & Switzky, 1978). Parents began to talk more openly about their children with mental handicaps and to demand more support and services. The social and political activism of the 1960’s and 1970’s began to influence attitudes toward the care of handicapped people (Tari & Fenn, 1988). This, added to the disappointment with the failure of institutional models to adequately serve this population, resulted in a rethinking of the possibilities (Menolascino, 1977).

Schools were willing to provide services for those with only mild problems, so parents started their own programs based on the belief that something could be done. Parallel trends were occurring within institutions where planners and direct caregivers were concerned with helping the residents realize their potential. This new awareness, along with exposés of poor institutional conditions, pressured governments to fund alternative programs. As a result, many group homes were opened as residential alternatives. These were part of a larger trend in human services paralleled with "half-way houses" for the mentally ill (Gollay et al., 1978).

At about this time the normalization principle was developing in Scandinavia and became the basis for community-based programs and services (Tari & Fenn, 1988). The definition of normalization includes:

allowing people with mental retardation to obtain and maintain an existence in as close proximity to and as much like the normal population as possible. (Bank-Mikkelsen, 1969, p. 244)

Elaborated by Nirje (1969) and Wolfensberger (1976), the principle has provided the foundation for the provision of services for people with mental handicaps.

Normalization stresses the delivery of services in environments and under circumstances that are as culturally normal as possible. If people with mental
handicaps cannot live with their families, then homes should be provided that are of a normal size and in a residential neighborhood. Isolation and segregation nourish public ignorance and prejudice, while integration and normalization in the lives of small groups of people with mental handicaps provide opportunities for ordinary interpersonal relationships on the basis of understanding and social acceptance for the individual (Wolfensberger, 1969). The principle "operates in terms of equality is part of the struggle for human rights for every person " (Bank-Mikkelsen, 1969, p.264).

Normalization as an ideology is important because it suggests models of service delivery. It is not a cure for people with mental handicaps, but rather it is an orientation offering relative independence of the individual as the highest goal (Braddock, 1977). Its emergence from Scandinavia coincided with the growth of the human rights movement in North America and so the adoption of the normalization principle became a part of the trend in human services to more individualized and community-based service delivery plans. Thus the pendulum swing of attitudes and provision of services has led to a re-integration of people with mental handicaps back to their communities.

Review of Studies

With the upsurge of interest in community-based services in the 1960's there have been a number of studies examining various aspects of the public's attitudes toward people with mental handicaps living in the community. The assumption that the more knowledge, information and contact people have with individuals who have a mental handicap the more tolerant and accepting they will be has been discussed by many researchers (Blackard & Barsh, 1982; Efron & Efron, 1967; Gale, Ng & Rosenblood, 1988; Gottlieb, 1975; Kastner et al., 1979; Roth & Smith, 1983; Willms, 1978). Several authors have argued that community acceptance is essential for
successful integration (Davidson, 1982; Gollay et al., 1978; Gottlieb, 1975; Holmes, 1979; Kastner et al., 1979). Various studies have looked at different aspects of the public's attitudes toward this population. Comparison of the results of these investigations is difficult because each study has asked different questions, often to dissimilar sample groups. There have been interesting and at times, contradictory findings. An overview of some of the studies on public attitudes toward community integration of people with mental handicaps follows.

In 1920, Fernald reported the results of the Waverly studies which addressed how previously institutionalized people coped in the community. The findings were contrary to his pessimistic expectations and Fernald subsequently modified his position when these studies showed how well these people did in the community. He concluded that many of those institutionalized could safely return to the community, given appropriate support (Heal et al., 1978). Little was reported on this topic until the President's Report on Mental Retardation (1964) rekindled interest in community attitudes and a number of large scale studies ensued. Efron and Efron (1967) measured the attitudes of 235 special and general educators using a Likert format questionnaire which included attitudinal and factual knowledge components. Findings showed special education teachers to be more tolerant, less authoritarian and more knowledgeable than general educators.

Gottwald (1970) conducted a large scale empirical study to determine the status of public knowledge about mental handicaps, as well as to discern public attitudes and to identify demographic characteristics from the data. He presented descriptive responses which indicated the general population's lack of knowledge and the persistence of myths and misconceptions. In 1976 the President's Committee on Mental Retardation contracted a Gallup survey which showed a generally positive acceptance of people with mental handicaps by most (85%) community members. The results implied that deinstitutionalization could proceed with little concern for
negative community attitudes. However, problems and limitations of the survey instrument used raise questions concerning its validity in measuring actual public attitudes.

There has been a call in the literature for follow-up and longitudinal studies following deinstitutionalization. Two comprehensive reports are particularly noteworthy. Return to the Community (Lord & Hearn, 1987) chronicles the process of closing a large institution and subsequent integration of individuals to their home communities in British Columbia. This qualitative, ethnographic investigation traced the experiences and perspectives of individuals, families, institutional workers, advocates and government staff prior to and during the closure process. It described and analyzed selected outcomes for individuals and their families and it identified main events and themes in the process. The study's scope and range have highlighted many implications for policy and practice. These include the importance of a planned transition from institutional to community living with input from the individuals involved, their families and caregivers, the necessity to share information, and the reality of a 'settling in' period for everyone involved.

In 1985, Conroy and Bradley produced a five-year longitudinal study on the court-ordered deinstitutionalization of the Pennhurst Centre in Pennsylvania. This comprehensive report includes sections on history, implementation issues, consumer satisfaction, family impact, neighbourhood attitudes and cost comparisons. It provides information useful when determining policies and processes for deinstitutionalization. These studies, with their wide perspectives and in-depth inquiries, offer valuable and comprehensive data for families, administrators and policy makers.

Other authors have presented studies on public attitudes toward people with mental handicaps. Reduced property value is often mentioned as a neighbourhood concern. Weiner, Anderson and Nietupski (1982), using realtor analytical methods in
two medium sized Iowa communities, found no negative property value effects and
two of the eight areas studied showed higher values. Results from Ryan and Coyne
(1985) also support the notion that group homes do not adversely affect
neighbourhood property values. In this study, data collected from 525 houses around
thirteen group homes showed no significant differences in the length of time on the
market and the ratio of the asking price to the actual selling price.

Some studies ask hypothetical questions. Seltzer (1985) postulated that the
relationship between expressed attitudes and actual behavior may be weak. This
concern has been addressed in other studies. Kastner et al. (1979) asked the same
questions as the Gallup poll but used a "threat" group of community residents, who
lived near a house for sale and were given the impression that a group home might
be established in their neighbourhood, and a "non-threat" control group. Ninety
percent of the control group and 81% of the threat group expressed accepting
attitudes, showing an openness even under the threat of a nearby group home. Gale,
Ng and Rosenblood (1988) found 16% of residents in Victoria, British Columbia,
were opposed to the location of a group home in their neighbourhood. Other studies
have produced contradictory results. Sigelman (1976) reported that only 45% of
respondents in an extensive survey in the southwestern U.S. favoured adult group
homes in residential areas. In another U.S. study of community attitudes, Roth and
Smith (1983) found 60% of respondents indicated they would not mind having a
person with a mental handicap as a neighbour.

A number of studies discuss the relative merits of informing the surrounding
neighbours prior to the establishment of a group home, versus the Machiavellian
approach of opening a home without advance notice. (Margolis & Charitonidis, 1981;
Sigelman, 1976; Willms, 1981). Efforts to prepare a community for a new group
home may increase the likelihood of community opposition to its opening
(Landsman-Dwyer, 1981). This supports the practice of many agencies of not
informing neighbours in advance and simply moving in unannounced, unsusceptible to organized protest (Heal, Sigelman & Switzky, 1978). Others oppose this Machiavellian approach and are concerned with maximizing the factors related to positive community acceptance and developing programs designed to improve attitudes toward people with mental handicaps (Gollay et al., 1978; Holmes, 1979).

Divergent viewpoints, a variety of questionnaires, variability in populations sampled, and hypothetical versus "threat" conditions have contributed to problems when comparing results across studies. The present investigation drew on several previous studies when formulating the knowledge and attitude questionnaires. The methodology, particularly the sampling and radiating proximity designs stem from Willms (1978). It examined the level of factual knowledge, the role of proximity to a group home and amount of previous contact with individuals who have a mental handicap. This study also collected demographic data on neighbourhood characteristics.

Summary

The origins and evolution of the community residence movement has varied origins including the civil rights movement, application of learning principles to the training and education of people with mental handicaps, normalization and parallel movements in the mental health domain, as well as debates about the relevance and validity of standardized test results and the judicial concepts of legal advocacy and the least restrictive environment. Institutional care developed in the mid-nineteenth century to train people with handicaps for community life and met this goal with mildly to moderately affected individuals. As people with more severe handicaps remained in institutions, custodial care became the norm, with little, if any, training occurring. This trend prevailed until the political and social activism of the 1960's and 1970's began to influence attitudes towards the care of people with handicaps.
The principle of normalization, formulated in Scandinavia, guided the development of community-based programs and services.

Studies which looked at public attitudes toward community integration for people with mental handicaps were first reported in the 1920's. There was little written on this topic for several decades until renewed interest in this population was triggered in North America with the creation of the President's Committee on Mental Retardation. Studies have looked at public attitudes, concerns, myths and misconceptions. Factual knowledge, amount of previous contact and proximity to group homes have emerged as important factors influencing community attitudes toward community integration of this population. The present study drew on several earlier investigations when formulating questionnaires and in particular on Willms (1978) in regard to methodological design and sampling procedures.
CHAPTER III. METHODOLOGY

This chapter has a twofold purpose. The first section describes the development of the survey instrument. The second section describes the design, variables, sample, data collection procedures and data analyses.

Instrumentation

To answer the research questions in Chapter I, a two-part questionnaire was developed. The first section measured the respondents' factual knowledge about mental handicaps while the second part was concerned with the respondents' attitudes toward people with mental handicaps. In addition the survey collected data on several demographic indices of the sample, as well as information about the respondents' past contact with people who have mental handicaps. The questionnaire aimed to determine whether there were differences in the level of knowledge or the attitudes in the three proximity groups described in Chapter I.

A review of the literature was unsuccessful in finding a questionnaire which targets these particular object referents and has an appropriate level of difficulty for the intended sample, that is, the general public. Therefore, a preliminary questionnaire was formulated drawing on a variety of sources (Efron & Efron, 1967; Gallup, 1976; Gottwald, 1970; Willms, 1978).

A pilot study for item screening was conducted using three distinct groups corresponding to the proximity model of the study. Nine students, enrolled in a one-year post-bachelor diploma program to train teachers of people with mental handicaps, represented the immediate neighbour group. Their knowledge about mental handicaps is considered noticeably above the norm for the general population as these students have taken at least three university-level courses in this area. In addition, due to their extensive student teaching experience, this group (based on the
assumption that increased contact fosters more accepting attitudes) represents people with more tolerant attitudes than the general public. A second group of two classes with fifteen students each, had completed an introductory course on mental handicaps, represented the intermediate neighbour group. These students had some contact with people who have a mental handicap and thus similar assumptions as those for the first group were made. The distant neighbour group representatives consisted of twenty-three individuals randomly selected from three Greater Vancouver Regional District neighbourhoods. These people represent a wide range of age, socioeconomic status and educational experience.

The initial survey consisted of two parts:
1. twenty-five true or false knowledge items.
2. thirty statements using a five-point Likert scale (1 - strongly disagree to 5 - strongly agree) comprising an attitude scale.

Each pilot study group completed the survey with instructions to respond to every item. There was no time limit given. Coded responses were entered into a datafile. The LERTAP (Nelson, 1974) item analysis and SPSS:X analysis of variance (SPSS, 1986) computer programs resulted in revisions and deletions. The revised instrument (see Appendix A and B) contains nineteen true or false knowledge items and twenty-one Likert-style attitude statements.

Design

To address the questions presented in Chapter I, the study used the survey instrument described earlier. Four group homes, located in distinct and separate areas of metropolitan Vancouver, formed the nuclei of the sample design. Each of the four areas was subdivided into three proximity groups: immediate, intermediate and distant neighbours. Each area's sample included seventy-five houses, twenty-five in each proximity group, totalling three hundred houses.
Variables

Dependent Variables

1. Knowledge about mental handicaps: This term is made operational by the use of a test developed to measure factual knowledge possessed by the study participants.

2. Attitudes toward integration: This term is made operational by the use of a Likert-type survey instrument based on existing scales in the literature, e.g. Efron & Efron (1967); Gottwald (1970); Willms (1978).

Independent Variables

1. Area: The sample is divided into four areas (A, B, C and D) based on the various neighbourhoods within the Vancouver region in which the group homes are located.

2. Proximity: The sample is divided into three groups based on their proximity to the group home:
   1. immediate neighbours - those homes on the same block or bordering on the group home lot
   2. intermediate neighbours - those houses within a 1000 foot radius of the group home
   3. distant neighbours - those houses within a 1400 foot radius of the group home
3. Contact: The respondents were rated based on their frequency of previous contact with people who have mental handicaps:

0 no contact
1 less than once a year
2 less than twelve times a year
3 monthly
4 weekly
5 daily

4. Ownership: The respondents were coded according to whether they rented or owned their residence:

0 rent
1 owned

5. Permanence of residence: The respondents were rated based on their length of residence in their present home:

1 less than one year
2 one to two years
3 more than two years

6. Socioeconomic status: The respondents were coded based on ratings derived from the 1981 Socioeconomic Index for Occupations in Canada (Blishen, Carroll & Moore, 1987). Students, homemakers and retirees were assigned the mean rating of all other respondents in the sample. These categories are not included in the index.
7. Age: Age of the respondents was coded as follows:
   - 20: less than 25 years old
   - 30: from 26 to 35 years old
   - 40: from 36 to 45 years old
   - 50: from 46 to 55 years old
   - 60: over 55 years old

8. Level of education: The respondents were coded according to the most advanced level of education attained.
   - 1: elementary school
   - 2: some high school
   - 3: completed high school
   - 4: some college or university
   - 5: completed university

9. Language: The respondents were coded according to their mother tongue.
   - 0: other
   - 1: English

10. Gender: The respondents were coded according to their sex.
    - 0: male
    - 1: female

Sampling Procedure

The sample was drawn from people living in the vicinity of group homes in the Greater Vancouver Regional District (GVRD) run by the Vancouver-Richmond Association for Mentally Handicapped People (VRAMHP). After obtaining permission from the University of British Columbia Ethical Review Committee and the VRAMHP to proceed with the study, the researcher found that four group homes met the criteria for inclusion in the study, that is, group homes with not more than
four adult residents per unit, at least one of whom experiences a severe handicap, and situated within a residential neighbourhood of the GVRD.

Random selection of three hundred houses within these neighbourhoods proceeded as follows. The researcher made copies of civic maps (GVRD, 1981) of each group home area. These maps, found in the UBC Map Library, indicate individual lots and type of dwelling thereupon. Centered at each group home the neighbourhoods were divided into the three proximity zones as described earlier. Each dwelling was numbered. Using a random number-generating computer program, twenty-five houses in each zone across the four areas were selected for inclusion in the study. These selections were then colour-coded on the maps. The exception was the immediate neighbour zone where the twenty-five dwellings closest to the group home were included. In the case of multiple dwellings, (e.g. apartment buildings) one unit was arbitrarily chosen to complete the questionnaire.

Data Collection

Six interviewers were recruited to collect data. All were students attending UBC; two undergraduates, three in diploma programs and one in graduate studies. Half of these students had experience in the field of mental handicaps. All interviewers underwent a training session in conducting the interview specific to this study. Each area of seventy-five houses had one or two data collectors.

Data were collected from June 10 to July 10, 1988 during the late afternoon and early evening hours in the following manner. Interviewers presented themselves at the door of a sample dwelling as identified on the map and stated that they were UBC students conducting a study concerned with public attitudes toward people with mental handicaps living in the community. They proceeded to give information about the aim of the study and the use of the results. The interviewers gave a quick overview of the respondents' role and time involvement as well as examples of the
demographic questions. They informed the householder that all responses were anonymous and participation completely voluntary. They also stated that if the questionnaire was completed, it was assumed that consent to participate had been given. It was also made clear that respondents could refuse to participate or withdraw from the study at any time.

If the respondent chose to participate the student continued with the interview schedule asking contact and demographic questions. The interviewer then left the questionnaire, which took approximately five to ten minutes to complete, and returned to pick it up, generally an hour or two later. In a few cases the respondents chose to mail the completed questionnaires to the researcher, whose name, university address and telephone number appeared on the cover sheet.

The schedules and questionnaires were coded by area and group for data entry purposes. Upon completion of their designated areas, the interviewers returned the maps, completed and uncompleted questionnaires and interview schedules to the researcher. The interviewers received an honorarium for their effort.

Data Analysis

Analysis of the coded data was conducted using the Statistical Package for the Social Sciences Extended Version SPSS:X (SPSS, Inc., 1986). Subprograms from the SPSS:X computer program produced descriptive statistics on all the variables. One way analyses of variance (ANOVA) tested the significance of differences between proximity groups between and within the four established areas. Three by four way ANOVAs tested proximity group by area interaction. The level of significance used throughout was 0.05.
Assumptions and Limitations

The procedure used for random sample selection supports the assumption that the respondents selected were representative of the neighbourhoods around the group homes. It was further assumed that these VRAMHP homes were representative of other group homes for people who have returned to the community. While several people may reside in each household, only one respondent per unit was selected. No gender was designated for selection and any adult at the residence could complete the questionnaire. It is assumed that these procedures did not introduce any specific selection biases into the sample that would prevent generalizing results to a larger urban population.

The sample size and return rate affects the validity of the results, and the generalizations that can be drawn from this study. There may be other types of group homes and neighbourhoods which would produce other results.

Summary

Six interviewers visited a total of three hundred randomly selected households near four group homes in the Greater Vancouver Regional District. They administered an interview schedule to collect demographic information at participating households, left a questionnaire to be completed by the respondent, and collected them soon after. The researcher coded and entered the data into a computer file. Statistical analyses were done using the SPSS:X program. The significance level used throughout was 0.05.
CHAPTER IV. RESULTS

Introduction

This chapter presents the results of the study which investigated the following research questions:

1. Does closer proximity influence neighbours' responses toward group homes?
2. Does factual knowledge affect neighbours' response to group homes?
3. What demographic factors contribute to neighbourhood acceptance of group homes?

This chapter presents summary descriptive data and analysis results. The first section contains descriptive data about the sample, the questionnaire return rate and the mean scores and standard deviations of the independent variables. The mean knowledge test scores are presented by group and area, followed by the mean attitude scale scores, also by group and area. The next section has analyses of variance results for the oneway ANOVA of independent variables by knowledge, then by attitude. The dependent variable section includes oneway ANOVA results for knowledge, then for attitude, by proximity group. The three by four way ANOVAs of the group by area for knowledge and group by area for attitude tested for interactions. A discussion section examines the results and addresses each research question. A summary of the findings concludes this chapter.

Descriptive Statistics

This study surveyed four neighbourhoods in the Vancouver-Richmond area. Each delineated sample neighbourhood centred around a group home for adults with mental handicaps. In each of the four areas, the sample consisted of 25 households
in each proximity group (immediate, intermediate, and distant) totalling 75 houses per area.

Table 1
Sample Size

<table>
<thead>
<tr>
<th>Area</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>300</td>
</tr>
<tr>
<td>Achieved</td>
<td>47</td>
<td>29</td>
<td>52</td>
<td>42</td>
<td>170</td>
</tr>
<tr>
<td>Return %</td>
<td>62.7</td>
<td>38.7</td>
<td>69.3</td>
<td>56.0</td>
<td>56.7</td>
</tr>
</tbody>
</table>

Table 2
Return Rate by Area and Proximity Group

<table>
<thead>
<tr>
<th>Area</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
<th>Return %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>19</td>
<td>14</td>
<td>21</td>
<td>16</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Group 2</td>
<td>13</td>
<td>9</td>
<td>16</td>
<td>12</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Group 3</td>
<td>15</td>
<td>6</td>
<td>15</td>
<td>14</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>29</td>
<td>52</td>
<td>42</td>
<td>170</td>
<td></td>
</tr>
<tr>
<td>Return %</td>
<td>62.7</td>
<td>38.7</td>
<td>69.3</td>
<td>56.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As shown in Table 1, the survey included three hundred households with responses from 170 participants. The return rate ranged from 38.7 percent in area 2 to 69.3 percent in area 3, with a mean return of 56.7 percent.

Table 2 shows the response rate by area and proximity group. These rates ranged from 24 percent (area 2, group 3) to 84 percent (area 3, group 1). The immediate neighbour group responded at mean rates of 56 percent to 84 percent. The intermediate and distant groups responded at 50 percent, with means ranging from 24 percent to 64 percent.
Table 3 presents the means and standard deviations of the independent variables by area. Area 2 showed the least amount of respondent contact with people who have a mental handicap, while Area 3 showed the most. The length of residency was similar across areas. There were relatively more renters than owners in area 4, but in all areas the majority of respondents were owners. Socioeconomic status means ranged from 42.71 to 50.78 on the Blishen scale. The standard deviations on SES ranged more widely in comparison to other variables. Area 3 in particular had an SES mean of 46.95 with a standard deviation of 18.72. This may be attributable to the suburban nature of this sample area, the only one not in the city of Vancouver. The average age varied from 37.1 to 41.9 across all four areas. Education level ranged from 3.39 to 4.07. A score of 3.0 indicates 'finished high school', 4.0 reflects 'attendance at a college or university', while 5.0 indicates 'completion of university'. The percentage of native English speakers is less in areas 1 and 2 than in areas 3 and 4, but still indicates a majority. Areas 3 and 4 are
strongly populated with respondents whose mother tongue is English. Gender is, nearly evenly distributed among participants in areas 2 and 4, while more women responded in areas 1 and 3.

Table 4

<table>
<thead>
<tr>
<th>Group</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>All Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area 1</td>
<td>11.33</td>
<td>13.44</td>
<td>11.14</td>
<td>11.80</td>
</tr>
<tr>
<td>Area 2</td>
<td>11.90</td>
<td>10.50</td>
<td>12.75</td>
<td>11.55</td>
</tr>
<tr>
<td>Area 3</td>
<td>12.88</td>
<td>12.42</td>
<td>12.00</td>
<td>12.45</td>
</tr>
<tr>
<td>Area 4</td>
<td>13.00</td>
<td>12.86</td>
<td>13.27</td>
<td>13.07</td>
</tr>
<tr>
<td>All Areas</td>
<td>12.33</td>
<td>12.33</td>
<td>12.12</td>
<td>12.26</td>
</tr>
</tbody>
</table>

Table 4 presents the mean knowledge scores by area and proximity group. Scores vary from a low of 10.50 (area 2, group 2) to 13.44 (area 1, group 2). The total sample population mean score was 12.26. The standard deviation was 1.87. Of the mean results for each proximity group, the two closer groups scored identically (12.33) while the distant group rated 12.12. The overall means for the different areas ranged from 11.55 to 13.07.

The mean attitude scores by area and group are found in Table 5. The scores ranged from 3.73 (area 4, group 3) to 4.27 (area 4, group 2). The highest score was from the smallest group in the entire study, with only four participants replying. The small sample size may have skewed the result. The next highest score was 4.14 (area 1, group 1). The overall mean for attitude across all areas and groups was 3.98. The mean scores of the proximity groups were nearly identical for group 1 (4.02) and 2 (4.04), and slightly lower for group 3 (3.88). The area means for attitude were relatively close, varying from 3.91 to 4.06.
Table 5

Mean Attitude Scores by Area and Group

<table>
<thead>
<tr>
<th>Group</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>( \bar{x} )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area 1</td>
<td>4.14</td>
<td>3.89</td>
<td>3.78</td>
<td>3.93</td>
</tr>
<tr>
<td>Area 2</td>
<td>3.86</td>
<td>3.97</td>
<td>4.27</td>
<td>3.97</td>
</tr>
<tr>
<td>Area 3</td>
<td>4.09</td>
<td>4.11</td>
<td>3.99</td>
<td>4.06</td>
</tr>
<tr>
<td>Area 4</td>
<td>3.92</td>
<td>4.18</td>
<td>3.73</td>
<td>3.91</td>
</tr>
<tr>
<td>( \bar{x} )</td>
<td>4.02</td>
<td>4.04</td>
<td>3.88</td>
<td>3.98</td>
</tr>
</tbody>
</table>

Analyses of Variance

Independent Variables

Oneway analyses of variance compared the independent variables with knowledge and attitude scores. These results are presented in Table 6 and Table 7.

In Table 6 the ANOVA compared the differences between the independent variables on the knowledge test scores. Knowledge scores compared by the amount of contact respondents had with people who have a mental handicap, the length of residency and ownership of the present dwelling, the socioeconomic levels, age and mother tongue of respondents did not differ significantly. Level of education affected the knowledge test scores at a statistically significant level of 0.01. As the education level of participants increased from "completed some high school" through "completed university" there was an increase on the knowledge test scores, ranging from means of 10.76 to 13.25. The other significant difference on knowledge test scores was by gender. Male respondents had a mean score of 11.97 while females scored a mean of 12.69. This was significant at the 0.05 level.
Table 6

One way Analysis of Variance of Knowledge Scores

by Independent Variables

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact</td>
<td>Between Groups</td>
<td>5</td>
<td>9.47</td>
<td>1.89</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>122</td>
<td>473.50</td>
<td>3.88</td>
</tr>
<tr>
<td>Residency</td>
<td>Between Groups</td>
<td>2</td>
<td>10.58</td>
<td>5.29</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>125</td>
<td>472.39</td>
<td>3.77</td>
</tr>
<tr>
<td>Ownership</td>
<td>Between Groups</td>
<td>1</td>
<td>3.43</td>
<td>3.43</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>126</td>
<td>479.54</td>
<td>3.81</td>
</tr>
<tr>
<td>SES</td>
<td>Between Groups</td>
<td>41</td>
<td>136.59</td>
<td>3.33</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>86</td>
<td>346.38</td>
<td>4.03</td>
</tr>
<tr>
<td>Age</td>
<td>Between Groups</td>
<td>4</td>
<td>18.72</td>
<td>4.68</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>123</td>
<td>464.25</td>
<td>3.77</td>
</tr>
<tr>
<td>Education</td>
<td>Between Groups</td>
<td>3</td>
<td>77.74</td>
<td>25.91</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>124</td>
<td>405.23</td>
<td>3.27</td>
</tr>
<tr>
<td>Language</td>
<td>Between Groups</td>
<td>1</td>
<td>9.11</td>
<td>9.11</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>126</td>
<td>473.86</td>
<td>3.76</td>
</tr>
<tr>
<td>Gender</td>
<td>Between Groups</td>
<td>1</td>
<td>15.94</td>
<td>15.94</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>126</td>
<td>467.02</td>
<td>3.71</td>
</tr>
</tbody>
</table>

* p < 0.05
### Table 7

**Oneway Analysis of Variance of Attitude Scores**

by Independent Variables

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact</td>
<td>Between Groups</td>
<td>5</td>
<td>1.13</td>
<td>0.23</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>126</td>
<td>23.16</td>
<td>0.18</td>
</tr>
<tr>
<td>Residency</td>
<td>Between Groups</td>
<td>2</td>
<td>0.03</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>129</td>
<td>24.25</td>
<td>0.19</td>
</tr>
<tr>
<td>Ownership</td>
<td>Between Groups</td>
<td>1</td>
<td>0.50</td>
<td>0.50</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>130</td>
<td>23.78</td>
<td>0.18</td>
</tr>
<tr>
<td>SES</td>
<td>Between Groups</td>
<td>41</td>
<td>7.83</td>
<td>0.19</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>90</td>
<td>16.45</td>
<td>0.18</td>
</tr>
<tr>
<td>Age</td>
<td>Between Groups</td>
<td>4</td>
<td>1.54</td>
<td>0.39</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>127</td>
<td>22.74</td>
<td>0.18</td>
</tr>
<tr>
<td>Education</td>
<td>Between Groups</td>
<td>3</td>
<td>0.42</td>
<td>0.14</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>128</td>
<td>23.86</td>
<td>0.19</td>
</tr>
<tr>
<td>Language</td>
<td>Between Groups</td>
<td>1</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>130</td>
<td>24.26</td>
<td>0.19</td>
</tr>
<tr>
<td>Gender</td>
<td>Between Groups</td>
<td>1</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>130</td>
<td>24.27</td>
<td>0.19</td>
</tr>
</tbody>
</table>
Table 7 presents the one-way ANOVA results of the independent variables with the attitude scale scores. These indicate no statistically significant differences on the attitude scores between the independent variables. The amount of contact the respondents had with people who have a mental handicap, the length of living at their present homes, and whether they owned or rented, did not make any significant difference on their attitude scale scores. The age variable show a mild trend that younger respondents (twenty to forty years of age) were slightly more tolerant than respondents over 40, but this was not statistically significant. Respondents' level of education, mother tongue and gender did not produce noticeable differences on their attitude scores. In summary, the difference between respondents' attitudes were not statistically significant when considering the independent variables examined.

Dependent Variables

One-way analysis of variance examined the differences on the dependent variables, knowledge and attitude by proximity group. These results are shown in Table 8 and Table 9.

As presented in Table 8, the mean scores on the knowledge test for the immediate group (12.32) and the intermediate group (12.33) were almost identical. The distant group scored slightly lower at 12.06. The one-way ANOVA resulted in no statistically significant differences between the immediate, intermediate and distant groups on these knowledge scores.

The analyses revealed that the attitude scale scores for the immediate group (4.00) and the intermediate group (3.99) were nearly equivalent. The distant group scored slightly lower with a mean of 3.88. The differences between these three proximity groups on the attitude scores were not statistically significant. These results do show a weak trend towards increasingly tolerant attitudes for those participants closer to the group homes.
Table 8

Oneway Analysis of Variance of Knowledge Scores
by Proximity Group

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>1.98</td>
<td>0.99</td>
<td>0.25</td>
</tr>
<tr>
<td>Within Groups</td>
<td>126</td>
<td>491.57</td>
<td>3.90</td>
<td></td>
</tr>
</tbody>
</table>

Table 9

Oneway Analysis of Variance of Attitude Scores
by Proximity Group

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>0.43</td>
<td>0.21</td>
<td>1.16</td>
</tr>
<tr>
<td>Within Groups</td>
<td>130</td>
<td>23.97</td>
<td>0.18</td>
<td></td>
</tr>
</tbody>
</table>

Interaction

A three by four way ANOVA explored possible interactions of the group for knowledge and group by area for attitude. There were no significant interactions.

Discussion

The study collected data from 170 households distributed over four neighbourhoods in the greater Vancouver area. The mean return rate for the entire sample was 56.6 percent. Summary data of the independent variables describe the sample by area. Other descriptive data include means for knowledge and attitude scores by area and proximity group.
Analyses of variance compared independent variables with knowledge and attitude scores, and were used to examine the dependent variables, knowledge and attitude, by proximity group. Three by four way ANOVAs investigated interactions between knowledge, area and proximity group and attitude, area and proximity group.

The first research question asked whether factual knowledge about mental handicaps influences the response of neighbours to group homes. Area 1 group 2 (13.44) and area 4 group 3 (13.27) had the highest means in knowledge scores. These cells did not score the highest on the attitude scores. This was similar for the lowest scoring cells in knowledge and attitude results. Given this evidence, and the lack of significant interaction effects from the three by four ANOVA, the present study results do not support the first research question.

Does proximity and contact influence neighbours’ attitudes toward group homes? The attitude scale mean scores for the immediate (4.02) and intermediate (4.04) proximity groups were nearly alike. The distant group was lower on this rating at 3.88. These differences are not statistically significant, however. This could indicate a mild trend but does not provide clear evidence that proximity to a group home influences attitude.

Area 3 had the highest means for amount of contact with people who have a mental handicap, and scored the highest on the attitude means scale. Area 2 had the lowest mean for amount of contact but was the second highest on the attitude scale. There were no statistically significant differences between area, group and attitude interactions. Although there is some evidence of a slight trend of increased contact and higher scores on an attitude scale, the differences between groups are not statistically significant, and thus this question cannot be clearly answered here.

The third question investigates what demographic factors might foster more positive neighbourhood attitudes. Of the eight indices included in this study, the
level of education and the respondents' gender were statistically significant on the results of the knowledge test. The higher the level of education attained, the better the results achieved on the knowledge items \( (p = 0.01) \). The female respondents' results were significant at the 0.05 level. However, none of the independent variables were significantly different on the attitude scale scores. This sample did not produce any clear indicators of demographic factors which foster acceptance of group homes by the neighbourhood.

**Summary**

This study provides no support that factual knowledge about mental handicaps influences neighbours' attitudes toward group homes. The proximity groups one and two had very similar scores on the attitude scale. The distant group rated slightly lower. While this difference is not statistically significant, it may indicate a trend that immediate and intermediate neighbours may have more tolerant attitudes towards group homes for people with a mental handicap. The data concerning the amount of contact is inconclusive, but a slight trend indicating increased contact could positively influence attitudes is suggested. Demographic factors including the amount of contact with people who have a mental handicap, the length of residency, whether the respondent owned or rented his or her home, the socioeconomic status, respondent's age, level of education, mother tongue and gender did not produce significant differences in participants' attitude scale scores. Level of education and gender were both statistically significant factors in respondents' knowledge ratings.
CHAPTER V. SUMMARY AND CONCLUSIONS

Summary

Over the last twenty years, there has been a movement to community living options for people with mental handicaps. The acceptance of group homes and their residents by neighbours has been discussed in the literature as an important factor in the success of this integration trend.

The study investigated neighbourhood attitudes toward group homes for people with mental handicaps in metropolitan Vancouver. It examined the public's knowledge about mental handicaps. The survey collected demographic information about the respondents. A total of three hundred households were surveyed, seventy-five in each of four areas. Each neighbourhood was subdivided into three concentric proximity groups: immediate, intermediate and distant. A group home formed the nucleus for each of these neighbourhoods.

The design of the study included two dependent variables, knowledge and attitude. It incorporated ten independent variables: area, proximity, amount of contact with people who have a mental handicap, home ownership, length of residency, socioeconomic status, age, level of education, mother tongue, and gender. Descriptive statistical and ANOVA procedures were conducted.

The study asked three questions:

1. Does factual knowledge about mental handicaps influence the response of neighbours to group homes?
2. Does closer proximity and increased contact influence neighbours’ attitudes to group homes?
3. What factors contribute to acceptance of group home residents by the surrounding neighbourhoods?
The first question about factual knowledge influencing attitudes is not supported by the results. The groups which scored highest on the knowledge test were not the same ones that scored well on the attitude scale. There were similar results for those who scored lower on the knowledge test and attitude scale. The present study results do not support the notion of factual knowledge about mental handicaps influencing attitudes toward people with mental handicaps. The next research question involved the relationship between increased proximity and contact influencing neighbours' attitudes toward group homes. There were no statistically significant results to answer this question, but there was some evidence of a mild trend that closer proximity to a group home influences attitude positively. There is slight evidence that an increased amount of contact with people who have a mental handicap may foster more positive attitudes, but these results were not statistically significant, and therefore this question cannot be clearly answered from these study results. The third question asks which demographic factors contribute to more positive neighbourhood attitudes. None of these indices were statistically significant on the attitude scale scores. Level of education and gender were significant at the 0.05 and 0.01 levels for the knowledge test. However, this sample did not produce any results indicating demographic factors that foster neighbourhood acceptance of group homes for people with mental handicaps.

Conclusions

The following conclusions are drawn:

1. The results of this study do not provide evidence that knowledge about mental handicaps influences neighbours' attitudes either positively or negatively.

2. Although not statistically significant, there is mild support indicating immediate and intermediate neighbours have more tolerant attitudes toward
people with mental handicaps. Proximity to group homes may be a factor influencing neighbours' attitudes.

3. There is no conclusive evidence that respondents with increased contact with people who have a mental handicap have more tolerant attitudes, but the data show a slight trend in this direction.

4. No demographic factors were found to be statistically significant when examining differences of results on the attitude scale. The knowledge test scores showed a significant difference on the level of education (p = 0.01) and gender (p = 0.05) variables.

Implications of the Study

This study looked at the effect of factual knowledge on respondents' attitudes toward group homes. It investigated the influence of proximity to and amount of contact with group homes for people with mental handicaps on neighbourhood attitudes. It attempted to identify demographic factors which contribute to tolerant attitudes towards group homes.

Although the results were inconclusive, two mild trends emerged. Closer proximity to group homes may foster more tolerant neighbourhood attitudes. Respondents who had increased contact with people who have a mental handicap had slightly more positive attitudes toward them. No evidence was found to support the idea that increased factual knowledge influences neighbours' attitudes toward group homes. No demographic factors were identified as contributing to more tolerant attitudes. Considering the assumptions and limitations discussed in Chapter 3, these results may be generalized to other large urban centres, but may not be applicable to smaller cities, towns, or rural areas.

Other findings included differences between people with varying levels of education, and female respondents, on the knowledge scores. These findings do not
answer the research questions of this study concerning attitudes, but are of interest when looking at the public's knowledge of mental handicaps.

The media and recent legislation have contributed to a number of changes in public awareness of people with mental handicaps and individuals with other disabilities. These include newspaper articles, news coverage and increased visibility of people with handicaps. As more people with mental handicaps live in neighbourhoods, they are using more community services and the public is becoming increasingly aware of their presence. Popular television programs now include characters with handicaps. Contemporary movies are addressing some issues for people with handicaps. In British Columbia, children with handicaps are now going to their neighbourhood schools, and this trend may engender more tolerant attitudes in the future.

Suggestions for Further Research

The results of this study suggest directions for future research. The moderate trends of positive attitudes of respondents with increased proximity and contact with people who have mental handicaps may be given additional support through a study with a larger sample. An increased number of respondents could strengthen the possibility of attaining statistical significance for these trends. Although the return rate of this survey was over fifty percent any way to increase the number of responses would be beneficial.

Refining the items on the knowledge test and attitude scale may increase the reliability of results. Using a larger, more diverse sample could facilitate more generalizable results.

The present study initially intended to interview managers about initial response to their group homes by the neighbours. The present managers were not
involved in the opening of these homes, so this information was not readily accessible.

Finally, conducting a similar study in ten year’s time, when more householders, especially children presently attending school with classmates who have handicaps, may reflect increased knowledge about and community contact with people who have mental handicaps. Comparing knowledge and attitudes then to those outlined in this study may show evidence of shifts in the public’s acceptance of people with mental handicaps in the community.
REFERENCES


APPENDIX A

INTERVIEW SCHEDULE
Introduction at the residence of the respondent:

Hello, I'm ___________ from the special education department of U.B.C. We are conducting a study pertaining to people's attitudes toward mentally handicapped people in the community. We are interested in seeing if there are differences in attitudes between people with different backgrounds or living in different areas. The information gathered will be useful in the planning and development of community awareness programs and more services for the mentally handicapped.

You will be asked a few brief questions regarding your contact with mentally handicapped people. Also there will be some general questions such as your type of work, education, mother tongue, length of residence, etc. You will be left a questionnaire about knowledge and attitudes toward the mentally handicapped. It will take 10 - 15 minutes to complete and will be picked up in a couple of days. All your responses will be kept completely anonymous. Your name and address will not appear on any form or questionnaire. If the questionnaire is completed it will be assumed that consent to participate has been given. You are free to refuse to participate or withdraw at any time.

While I'm here I'd like to ask you a few general questions which pertain to our study. It will only take a few minutes.

If the respondent agrees, state:

Our study is concerned with people's attitudes toward the mentally handicapped and their knowledge about mental handicaps. People with mental handicaps may have a range of problems from mild to severe. Most individuals with mild mental handicaps learn to become self-supporting and live independently in the community, given some understanding and, at most, occasional help or support. Moderately mentally handicapped people learn to care for themselves and with appropriate training most can be at least partially self-supporting and live in the community with some supervision. People with severe handicaps often find it difficult to communicate verbally and are often unable to take care of themselves without help.

People with mental handicaps are sometimes referred to as mentally retarded.
1. Have you ever known a person whom you thought was mentally handicapped?

2. If yes, under what circumstances did you know that person?
   1. an immediate family member
   2. a relative of yours
   3. someone in the neighbourhood
   4. a friend of the family
   5. a casual acquaintance
   6. other, please specify

3. If yes, how often would you be in contact with this person?
   1/month, 1/week, daily?

4. How long have you lived at this present address?

5. Do you own or rent it?

6. What kind of work do you usually do?

7. What kind of business or industry is it?

8. Would you mind telling me in which of these age brackets you belong?
   1. under 25
   2. 26-35
   3. 36-45
   4. 46-55
   5. over 55

9. How far did you go in school?

10. Is English your first language?

11. If no, would you mind looking at the first part of the questionnaire to see if it would be too difficult to understand?

If too difficult, or there is some hesitation:

I'm sorry that we don't have the questionnaire prepared in other languages. That will be all the information we need. Thank you very much for your cooperation.

12. Sex:  M
     F

Additional notes or comments:

Thank you. Now I would like to leave this questionnaire with you. I want to remind you that your responses will be kept completely anonymous. We will stop by in two or three days to pick it up. Do you have any questions? Thank you again for your cooperation.
APPENDIX B
QUESTIONNAIRE
This study is looking at neighbourhood attitudes toward people with mental handicaps living in the community. It examines the public's knowledge of mental handicaps and their attitudes toward community integration. The information gathered will be useful in the planning and development of community awareness programs and more services for the mentally handicapped.

Researchers will ask some demographic questions and explain the project in a 10 minute interview. Participants will be left a questionnaire which will take approximately 15 minutes to complete. It will be picked up later.

The participants responses will be kept completely anonymous. Names and addresses will not appear on any form or questionnaire. If the questionnaire is completed it will be assumed that consent has been given to participate in the study. You can refuse to participate or withdraw at any time.

Researcher: Rosemary Love
Department of Educational Psychology
and Special Education
University of British Columbia
People with mental handicaps show a range of problems from mild to severe. Most individuals with mild mental handicaps learn to become self-supporting and live independently in the community, given some understanding and, at most, occasional help or support. Moderately mentally handicapped people learn to care for themselves and with appropriate training most can be at least partially self-supporting and live in the community with some supervision. People with severe handicaps often find it difficult to communicate verbally and are often unable to take care of themselves without help.

People with mental handicaps are sometimes referred to as mentally retarded.

PART 1

1. In most cases the cause of mental handicaps can be identified. T F
2. Studies show that mentally handicapped people are generally happier than most other people. T F
3. People who have mental handicaps usually need institutional care. T F
4. Early training can reduce the severity of mental handicaps. T F
5. Mental handicaps are usually inherited. T F
6. A person’s degree of independence and social skills partly determines whether they would be considered mentally handicapped. T F
7. Mental handicaps are more common among people in the lower socioeconomic classes. T F
8. People with mental handicaps are usually recognized before school age. T F
9. Mentally handicapped people are more successful at work than they are at school. T F
10. There is little difference between the various degrees of mental handicaps. T F
11. Most mentally handicapped people would also be considered mentally ill. T F
12. Sheltered workshops for mentally handicapped people are usually self-supporting. T F
13. Mentally handicapped people are dangerous. T F
14. Eight percent of the population has some degree of mental handicap. T F
15. Mentally handicapped people are prone to violent behaviour.  
   T F

16. The percentage of people with mental handicaps in our society has markedly decreased in the last twenty years.  
   T F

17. IQ scores are, in part, used to determine if a person has a mental handicap.  
   T F

18. Even psychologists cannot say definitely whether some people are mentally handicapped or not.  
   T F

19. A person considered to have a mental handicap in an urban society might not be considered handicapped in a rural setting.  
   T F

PART 2

Here is a list of statements about people. For each statement please circle if you strongly agree (5), agree (4), neither agree nor disagree (3), disagree (2), or strongly agree (1).

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>strongly agree</td>
<td>agree</td>
<td>neither agree</td>
<td>disagree</td>
<td>strongly disagree</td>
</tr>
</tbody>
</table>

1. People with mental handicaps can be as happy as anyone.

   5  4  3  2  1

2. Little can be done to help someone with a mental handicap.

   5  4  3  2  1

3. Mentally handicapped people should have the same rights as anyone else.

   5  4  3  2  1

4. There are good reasons to fear people with mental handicaps.

   5  4  3  2  1

5. You can generally identify mentally handicapped people by their appearance.

   5  4  3  2  1

6. Mental handicaps often lead to mental illness.

   5  4  3  2  1
5 strongly agree 4 agree 3 neither agree nor disagree 2 disagree 1 strongly disagree

7. I would not mind if a person with a mental handicap worked where I do.
   5  4  3  2  1

8. A married couple with mental handicaps should not have children.
   5  4  3  2  1

9. People with mental handicaps have the right to a public education.
   5  4  3  2  1

10. A mentally handicapped person should not expect to participate in community activities.
    5  4  3  2  1

11. Mentally handicapped adults living in my neighbourhood would tend to lower the value of my property.
    5  4  3  2  1

12. People with mental handicaps should not marry.
    5  4  3  2  1

13. Mentally handicapped people should live in the community.
    5  4  3  2  1

14. Most mentally handicapped people have no feelings about their handicaps.
    5  4  3  2  1

15. Most mentally handicapped people would make good neighbours.
    5  4  3  2  1

16. Mentally handicapped people should have the same access to medical care as anyone.
    5  4  3  2  1

17. Most mentally handicapped people would be reliable employees.
    5  4  3  2  1
Most parents of children with mental handicaps can have other non-handicapped children.

5 4 3 2 1

Most people with mental handicaps should vote.

5 4 3 2 1

Most mentally handicapped people can have normal children.

5 4 3 2 1

I would not want my child to play with a mentally handicapped person.

5 4 3 2 1
APPENDIX C

RAW DATA