

When the Neighbors Complain: Correlates of Neighborhood Opposition to Sheltered Care Facilities

**Carol J. Silverman, Ph.D.
Steven P. Segal, Ph.D.**

Abstract: Neighborhood resistance to unwanted land uses is a much heralded but insufficiently investigated feature of recent decades. This paper investigates local opposition to sheltered care for a people with mental disabilities. Using data gathered in a 12 year follow-up of a probability sample of sheltered care facilities in California, the study looks at changes over time in local opposition and at correlates of local reaction. It concludes that opposition is not related to typically proposed factors such as social class, inner-city location, or neighborhood cohesion but instead to the amount of disability of the residents, the ties of the operator to the neighborhood and location in an outer suburb.

With deinstitutionalization, patients moved from the psychiatric hospital system to the community. Among other alternatives, they entered sheltered care facilities, privately run group housing that provided at minimum a bed and meals, and at maximum important supplemental medical and other care (Segal & Kotler, 1989). By 1980 there were more former psychiatric inpatients (FPIs) living in sheltered care than had lived in the entire hospital system at the outset of deinstitutionalization (Goldman, Gattozzoti, & Taube, 1981).

Deinstitutionalization was to integrate FPIs into the community; yet, the community has not always accepted them. Reputedly, during the past several decades there has been an increase in the amount of negative neighborhood reaction to undesirable land uses in general and to the siting of sheltered care facilities in particular. Popularly known as "NIMBYism

The first author serves as program director, Center for Self-Help Research, Berkeley California. The second author serves as Director, Social Welfare Research Group, School of Social Welfare, University of California at Berkeley and as an Editorial Board Member, *Adult Residential Care Journal*. The research for this article was supported by the Robert Wood Johnson Foundation and the National Institute of mental Health.

Request for reprints should be sent to Carol J. Silverman, 1918 University Avenue, Suite 3D, Berkeley, California, 94704.

Editorial inquiries to Carol J. Silverman (510) 849-0731.

Not for quote or publication without permission of author.

(not in my backyard) against LULU's (locally undesirable land uses)," neighborhood actions have ranged from complaints to organized resistance to harassment (see e.g., Piasecki, 1975; Ludlow, 1977; Segal & Aviram, 1978; Baron & Piasecki, 1981). NIMBYism's effect on the ability of FPIs to make their homes in the community has yet to be fully documented; clearly it has contributed to their housing problems. A study conducted by Horizon House estimates that half of all sheltered care facilities were prevented from opening, or have to close because of neighborhood resistance (Baron, Rutman, & Klaczynska, 1980).

As a consequence of this discrimination, the Fair Housing Act of 1966 was amended in 1988 to include physical and mental disabilities. The amended act prohibited discrimination in the sale or rental of any housing based upon the "handicap" of the tenant. The act further prohibited municipalities from enacting particular rules or restrictions governing housing for people with mental and other disabilities. (See Petril & Ayers, 1994 for a summary of court cases pertaining to this act).

However, legislation does not, of course, mandate that the actual residents of a neighborhood accept their neighbors—something that is necessary for full integration of people with mental disabilities into the surrounding community. Arens (1993), for example, reports on neighborhood opposition to facilities for FPIs in Long Island. At the time of this opposition, the New York State Site Selection Law prohibited discrimination in local zoning against small facilities. Even if facilities are able to open—perhaps after court action—neighbors can still make the experiences of their new residents more or less pleasant. In this study we look at the experiences of operators of sheltered care facilities. We ask what types of neighborhoods and facilities generate the least opposition. Rather than consider the formation of new facilities, we look at reactions to existing dwellings, both before and after opening. This is important in its own right. There is a good deal of literature on strategies to overcome initial local opposition (e.g., Raush & Raush, 1968; Berdiansky & Parker, 1977; Goldmeir, Sauer, & White, 1977; Stickney, 1976; Hogan, 1986a; Cheung 1990); There is less on how facilities, once they have opened, can be accepted into their neighborhoods (Hogan, 1986a is an exception). The topic is also important since analysis of opposition to proposed new facilities must look at actions, such as petitions, directed to the public sector. Complaints to the owner/operator or vandalism are less likely before a facility opens since the person does not yet reside in the area. As such, investigation only of reactions against proposed facilities concentrates on the actions of neighborhoods capable of using public channels; this may be a class based phenomena (Smith, 1981; Logan & Molitch, 1987; Hogan, 1989; Graham & Hogan, 1990).

Previous Research

The literature on NIMBYism and sheltered care does not differentiate between factors that affect pre-post-opening complaints. In looking at

complaints in general, the literature focuses on characteristics of the facility and neighborhood. Authors generally assume, with some supporting documentation, that residents who are more disabled or are perceived as more threatening generate more hostility; similarly, residences that look like group homes are less favorably received (Wenocur & Belcher, 1990).

Writings on neighborhood predictors have generally accepted notions common in much of the community literature. Neighborhoods thought to be most likely to oppose facilities are characterized by a sense of common identity and attachment. Citing Suttle's (1970) concept of a "defended neighborhood," authors hypothesize that people will resist LULU's when they live in a defined area with a cultural, class, or ethnic identity as well as tightly knit local ties.

The community literature recognizes that most neighborhoods do not fit this definition, yet can mobilize. Even when there is no common neighborhood identity, interlocking social ties are thought to give impetus to organization (O'Brien, 1975; Warren & Warren, 1977; Boyte, 1984). Further, people can develop ties of "limited liability," (Janowitz, 1967) activated only when there is a pressing local issue. Currie, Trute, Tefft, and Segall (1989) for example see such neighborhoods as intermediately likely to react. However, when people have no attachment to the neighborhood they are less likely to complain, choosing instead to move when the situation becomes intolerable.

Thus, the literature generally hypothesizes that more socially integrated neighborhoods and people more invested in their surroundings will be more likely to resist LULU's (see, e.g., Davidson 1981; Currie et al., 1989; Wenocur & Belcher, 1990). Social integration is operationalized as residential stability, homeownership and married couples with children (Davidson, 1981; Dear & Taylor, 1982; Taylor, Hall, Hughes, & Dear, 1984; Currie et al., 1989). There is the accompanying expectation that higher income people, who perhaps have more political resources and thus a greater chance of effectiveness or perhaps greater investment in the neighborhood, will also show more resistance (Taylor et al., 1984; Currie et al., 1989; Wenocur & Belcher, 1990). Conversely, neighborhoods least likely to object are lower income transitory neighborhoods, often characterized by mixed land-use (Herstein, 1964; Rausch & Rausch, 1968; Berdiansky & Parker, 1977; Goldmeir, Sauer, & White, 1977; Davidson, 1981; Dear & Taylor 1982; Taylor et al., 1984).

Expectations about neighborhood resistance are attached to geographic locations. Center cities are seen as the most hospitable and suburban locations the least (Rausch & Rausch, 1968; Keller & Alper, 1970; Berdiansky & Parker, 1977; Davidson, 1981; Taylor et al., 1984; Marshall, 1989; Wenocur & Belcher, 1990). Rural locations, insofar as the sheltered care facility is self-contained and does not use local facilities, are also seen as good locations (Rausch & Rausch, 1968).

There are problems in underlying theory and in actual research. The neighborhood organization literature shows that the most active organizations are not found in neighborhoods of high cohesion (Henig, 1982)

and that local friendships do not necessarily reinforce political action (Silverman & Barton, 1994). Such neighborhoods are too complacent. Instead, neighborhoods where there are conflicts among the residents are more likely to take action (Crenson, 1983). Furthermore, we do not know if actions directed against facilities are the result of strong organizations of many individuals or if they result from the anger of one or two very motivated people (see Hunter & Staggenberg, 1986). Hogan (1986b) found that opposition was not a function of residents' perception of the degree of neighborliness in the area; Orcutt and Cairl (1976) found that most neighborhood residents did not take part in actions directed against a facility, in spite of the large amounts of attention such activities gathered; Dear and Taylor (1982) found that only a very few individuals had taken part in actions against facilities.

The literature is further empirically incomplete. Some is based on practitioner experience and, as such, lacks the comparative framework necessary to show association. Many empirical studies survey attitudes. While this is informative, showing for example that many neighbors of sheltered-care facilities are unaware of their existence (Dear & Taylor, 1982; Rabkin, Muhlin, & Cohen, 1984; Wahl, 1993), the link between what people say and what they do has not been documented (the literature on the problematic consistency of attitude and behavior is immense). Link and Cullen (1983) and Dear and Taylor (1982) discuss the consistency of attitude and behavior toward people with mental disabilities. Furthermore, there is the problem of an ecological fallacy. An angered individual, lacking the sympathy of neighbors, *might* be more likely to take hostile action when he or she lives in a neighborhood where the "average" opinion is more positive. Finally, a few studies such as Davidson (1981) look at where facilities exist as a proxy for NIMBYism—an unproven relationship—or at actual actions (Wenocur & Belcher 1990).

The evidence from the research is inconclusive, undoubtedly reflecting the difference in outcome measures. Hogan (1986b), for example, finds more opposition by self-reported social class; Wenocur & Belcher (1990) find no relationship between opposition and objectively measured class; Davidson (1981) and Currie et al. (1989) found more opposition by homeowners; Wenocur & Belcher (1990) found no association between class and opposition. Currie et al. (1989) found more reactions in neighborhoods undergoing a major improvement.

Because of the differences in measurement and in variables considered, it is difficult to state with any assurance which of the many proposed variables matters. Here, we attempt a full test of all of the factors mentioned in the literature, using a range of actual negative actions as outcome measures.

We summarize much of the literature in constructing our hypotheses. We first test whether facilities and residents that most deviate from the stereotype of a "normal" residential land-use generate the most opposition. We also test whether people who are more invested in their neigh-

borhood and have greater expectations that it only contains "normal" residential uses also generate more opposition.

Methods

Our analysis is based upon data gathered by the second author in a probability cluster sample of 214 residential care facilities located in California in 1973. The initial sampling frame included all family care, board and care, and halfway houses in California serving at least one mentally disabled resident.

To secure the frame, the state was divided into three master strata: Los Angeles county, the nine county Bay Area and all other counties. Facilities were stratified by size in both LA and the Bay Area and samples of facilities were drawn with probabilities proportionate to bed capacities. In the stratum composed of all other counties, two counties were selected from the north of the state and two from the south with probabilities proportionate to capacity. From each pair, a sample of facilities was selected, again with probabilities proportionate to size. The sample of facilities then is a self-weighting probability sample representative of all 1,155 facilities in the state during the summer of 1973. (See Segal and Aviram, 1978 for further details of the sampling procedures).

Facilities were re-contacted between 1983 and 1985 and current managers interviewed. Of the original 214 facilities, 156 were still open at the later date. Interviews were completed with 151 (97%) of the managers. Census tract information was compiled for all facilities from the 1980 censuses.

Variables

Dependent.—In both 1973 and 1985, operators were asked if neighbors had complained about the facility, if the operator or her/his family had been threatened or harassed by neighbors because of the facility and if neighbors had gone to the authorities because of the facility.

Independent.—If neighbors are more likely to react to facilities and residents that are more clearly distinguishable from the other neighborhood uses, such difference should be indicated by:

1. Facilities that house a greater number of more seriously disabled individuals. Operators were asked the number of residents in the facility who had a mental disability. They then reported the number of those with a mental disability who could not presently be employed, had a history of psychiatric hospitalization or had been treated in a hospital setting in the past year. A principle components factor analysis was computed (see Table 1) and the resulting factor score used.
2. Resident behavior: Operators were asked for the numbers of residents with a mental disability who had been picked up by the police in the past year.
3. Facilities whose physical plant does not resemble a "normal" resi-

Table 1
Factor Analysis

	Factor loading
1. Disability Residents	
<i>N</i> with History of Mental Illness	.99
<i>N</i> with History of Psychiatric Hospitalization	.99
<i>N</i> Treated in Psychiatric Hospital Last Year	.66
<i>N</i> Unable to Enter Workforce	.98
% Explained Variance	.85
2. Localism Operator	
Time in Facility	.79
Lives in Facility	.64
Owens Facility	.79
% Explained Variance	.55
3. Poverty	
% Below Poverty Line	.82
% Unemployed	.82
% Explained Variance	.68
4. SES of Neighborhood	
Mean Education	.94
Mean Income	.54
% Managerial/Professional	.93
% Explained Variance	.68

dence—that is, is not a single family dwelling. The facility was coded for whether it was a single family dwelling.

- Facilities whose operator is less a part of the neighborhood—rents rather than owns, does not live in the facility and has been involved with the facility and in turn with the neighborhood for shorter periods. Operators were asked whether they (a) owned the building, (b) lived there, and, (c) the amount of time they had been involved with the facility. Preliminary analysis suggested that there was a large amount of co-variance in the explanatory power of these variables, so a factor score was computed (see Table 1).
- Facilities where there is a high turn-over of residents rather than a stable population. Turnover was measured by the percent of the residents who had lived in the facility for six months or less.

Facility-Neighborhood Factors

- Facilities whose residents more closely resemble the other neighborhood residents should generate less resistance. In particular, there will be less resistance when there is a residential match and when the typically poor facility inhabitants live in a lower income census tract. The

1980 census data available to us permits only ascertainment of the percent of Caucasian, African-American and other households. Therefore we computed a match variable, coded as one if the facility and the neighborhood residents "matched," that is, both were at least 50 percent Caucasian or both were at least 50 percent African American and zero otherwise. A factor score measuring poverty was computed using the census data from the percent having incomes below the poverty level and the percent unemployed in the area (Table 1).

2. Neighbor involvement of the residents: It is unclear how the involvement of residents of the facility should affect negative reactions. On the one hand, neighbors who are friendly with facility residents show acceptance of at least some members of the facility and perhaps have less reason to complain. However, neighborhoods are composed of many people and the behavior of one may say nothing of the actions of another. Furthermore, neighbors are often unaware of the existence of a sheltered care facility. Facilities where residents are more locally involved may create awareness of their existence and accompanying complaints. A neighbor involvement was coded as one if any of the facility's residents had been invited to a neighbor's home or chatted on the street and zero otherwise.

Other Neighborhood Factors

NIMBYism is thought to be found in neighborhoods where people have greater ties to the area and where they possess greater political resources to use those ties.

1. Socioeconomic State (SES): Census data were collected for the median income, mean education, and percent of employed holding professional or managerial occupations. A factor score was computed from the three measures (Table 1). We also measured change in class composition by creating a similar factor score for 1973. Following a modification of Covington and Taylor (1980) we separately rank ordered all census tracts on the 1970 and 1980 factors. The one with the lowest SES had a rank order of one, the second lowest of two and so on. We then took the difference between the two rank order scores as our measure of change in SES.
2. Percent homeowner: measured from census data.
3. Family orientation: measured by the percent of the population in the census tract who are under age 16.
4. Residential stability: measured by the percent of the population in the census tract who have been in their dwelling for more than one year.
5. Ecological location: measured by a series of dummy variables indicating if the facility was located in the central city of a consolidated metropolitan statistical area (CMSA) in a suburb contiguous with the central city, in an outer suburb or outside a CMSA. This division was used because previous work has shown the populations of inner and outer suburbs do not act the same way on many issues (Fischer, 1977).

Table 2
Pearson Correlation Coefficients

	Correlation w/aggregate complaints 1985	Variables in final regression mode			
		Disability R.	Single family dwell- ing	NBHR. In.Op	Out- er sub- urbs
Facility/Operator Characteristics:					
Disability Residents	.41***	1.0			
Single Family Dwelling	-.34**	-.31**	1.0		
N Residents Picked Up by Police	.04				
Facility Residential Turnover	.10				
Facility/Neighborhood Characteristics:					
Neighborhood Involvement Operator	-.37**	-.32**	.42**	1.0	
Resident Neighboring	-.16				
Ethnic Match	-.10				
Poverty Neighborhood	-.07				
Neighborhood Characteristics:					
Urban	-.08				
Inner Suburbs	-.10				
Outer Suburbs	.16	-.14*	.00	-.03	1.0
SES Neighborhood	.09				
Change in SES	-.07				
% Homeowner	-.04				
% Children	-.05				
Nbhd Residential Stability	-.11				
Mixed Land-Use	-.09				

* $p < .05$.

** $p < .01$.

*** $p < .001$.

6. Land-use: operators were asked to categorize the mixture of residential and non-residential uses. A variable was created comparing the purely residential neighborhoods with the mixed use ones.

Results

The data permit two comparisons of neighbor reaction to the facility. We can see if reactions before the facility opened continue in the later period and whether reactions in 1973 predict those in 1985. Moreover, we can see if there has been an increase in complaints over the 12 year period.

In all, 16 operators (8 percent) reported that complaints had been made about the facility, either directly to them or to the owners before it had opened. Thirty-seven (18 percent) reported complaints between the time

the facility had opened and the date of the 1973 interview (we have no way to standardize for the time the facility had been open). Facilities that experienced complaints before opening were significantly more likely to do so afterwards. Forty-four percent of those who had received later complaints also received earlier ones. This means that over half of those who received pre-opening complaints did not hear from their neighbors again. Only 15 percent received complaints only in the post opening period. Furthermore, a paired *t*-test shows that facilities that experienced reactions in 1973 were not significantly more likely to evidence them in 1985 ($t = 1.45, p = .15$).

We next look at what predicts hostile reactions in the 1985 data. An index was created by summing whether a complaint had been made to the operator, a complaint had been made to the authorities and whether the operator or family had been harassed because of the facility. The alpha for the index was .56, largely because of the lower correlation of harassment with the other two items. It was decided to keep all three items because of the fact that people might choose to express anger or unhappiness differently, depending on ease of using official channels versus direct actions against an owner. Thirty-two percent of the facilities experienced such negative reactions.

The literature mentions many possible predictors, too many to examine conjointly. Instead, we look at the bivariate correlations to discard the non-significant predictors before developing our multivariate models. To test for suppressor effects, all non-significant variables were added to the final multivariate model, one at a time. None of them—except ecological location (discussed below)—altered the interpretation.

As shown in Table 2, most variables thought to be important in the literature are not predictive. Looking at facility variables, neighborhoods did not respond differently to facilities where more of the residents had been picked up by the police. The match between facility and neighborhood ethnicity and resident involvement with neighbors were also not predictive. Finally, looking at neighborhood factors, reaction was not predicted by mixed land use, the socio-economic class of the area (either as a continuous variable or as a direct measure of poverty), change in class composition, the percent of children, location in an inner city poor area, residential stability or the percent of homeowners in the area.

Instead, as shown both in the bivariate correlations and in the multivariate models in Table 3, neighborhood reaction was first dependent on the number of more seriously mentally disabled residents. Secondly, it depended on the extent to which the facility and its operator more closely fit the stereotype of a normal residence—that is it was a single family dwelling and it had a resident owner/operator who owned the building and has lived there for a longer period. Finally, the ecological location matters, but not quite as simply as initially predicted. The bivariate association between outer suburban location and neighborhood location is not significant until we control for the disability of the residents. Facilities in the outer suburbs have less disabled residents, and less disabled resi-

Table 3.
Regression Predicting Aggregate Complaints 1985

	b	B	Sig.
Disability Residents	.28	.33	.000
Nbdh Involvement of Operator	-.15	-.20	.003
Single Family Dwelling	-.24	-.15	.028
Outer Suburb	.26	.17	.004
Constant	.52		
R ² .28			.000

dents are less likely to create a reaction. However, once this is controlled, suburban location is significant. Suburban areas are more hostile than other ecological locations.

Discussion

Facilities do best when the operator shows attachment to the neighborhood by living there, owning the dwelling and establishing a longer tenure. While the number of facility residents, alone, does not matter, the number of more seriously disabled ones does. Furthermore, facilities do least well when they are located in the outer suburbs.

NIMBYism appears to be evenly spread across most ways the population is divided, being unrelated to housing tenure, SES, stage in the life-cycle and so forth. It may be that the association between reaction and class does exist only if we look at more organized actions such as complaints to public officials and at the success of these actions. This study looks at less formal actions and finds no association.

The findings support the practitioner experience that the most accepted facilities are the ones most resembling other residences—because the owner is a member of the neighborhood and because there are fewer mentally disabled residents. However, it also shows that the literature's emphasis on social action stemming from neighborhood integration may be misplaced. It assumes that action is created by a community rather than from separate households' attachment to their particular dwelling and to their idea of what the surrounding neighborhood should be.

Finally our findings indicate that facilities able to become established in spite of local opposition need not face continuing pressure, that neighborhoods can learn to live with sheltered care facilities in their midst.

References

- Arens, D. A. (1993). What do the neighbors think now? Community residences on Long Island, New York. *Community Mental Health Journal*, 29(3), 235-245.
- Baron, R. C., & Piasecki, J. R. (1981). The community versus community care. In R. D. Budson (Ed.), *Issues in community residential care* (pp. 63-66). San Francisco: Jossey Bass.

- Baron, R. C., Rutman, I. D., & Klaczynska, B. (Eds.), (1980). *The community imperative: Overcoming public opposition to community care for the mentally ill*. Proceedings of a national conference. Philadelphia: Horizon House.
- Berdiansky, H. A., & Parker, R. (1977). Establishing a group home for the adult mentally retarded in North Carolina. *Mental Retardation*, 14(4), 8-11.
- Boyte, H. C. (1984). *Community is possible: Repairing America's roots*. New York: Harper and Row.
- Cheung, F. M. (1990). People against the mentally ill: Community opposition to residential treatment facilities. *Community Mental Health Journal*, 26(2), 205-212.
- Covington, J., & Taylor, R. (1980). Gentrification and crime. *Urban Affairs Quarterly*, 25(1), 142-172.
- Crenson, M. (1983). *Neighborhood politics*. Cambridge: Harvard University Press.
- Currie, R., Trute B., Tefft., B., & Segall, A. (1989). Maybe on my street: The politics of community placement of the mentally disabled. *Urban Affairs Quarterly*, 25(2), 298-321.
- Davidson, J. L. (1981). Location of community based treatment centers. *Social Service Review*, 55(4), 221-241.
- Dear, M. J., & Taylor, S. M. (1982). *Not on our street*. London: Pion.
- Fischer, C. (1977). *To dwell among friends: Personal networks in town and city*. Chicago: University of Chicago Press.
- Goldman, H. H., Gattozatti, A. A., & Taube, C. (1981). Defining and counting the chronically mentally ill. *Hospital and Community Psychiatry*, 32, 21-27.
- Goldmeir, J., Sauer, J. R., & White, E. V. (1977). A halfway house for mentally ill offenders. *American Journal of Psychiatry*, 134(1), 45-49.
- Graham, L., & Hogan, R. (1990). Social class and tactics: Neighborhood opposition to group homes. *The Sociological Quarterly*, 31(4), 513-529.
- Henig, J. (1982). *Neighborhood mobilization, redevelopment & response*. New Brunswick: Rutgers University Press.
- Herstein, N. (1964). What is a group home? *Child Welfare*, 43(8), 403-404.
- Hogan, R. (1986a). Gaining community support for group homes *Community Mental Health Journal*, 22(2), 117-126.
- Hogan, R. (1986b). Community opposition to group homes. *Social Science Quarterly*, 67(2), 442-449.
- Hogan, R. (1989). Managing local government opposition to community based residential facilities for the mentally disabled. *Community Mental Health Journal*, 25(1), 33-41.
- Hunter, A., & Staggenborg, S. (1986). Communities do act: Neighborhood characteristics, resource mobilization and political action by local community organizations. *The Social Science Journal*, 23(2), 169-180.
- Janowitz, M. (1967). *The community press in an urban setting: The social elements of urbanism*. Chicago: University of Chicago Press.
- Keller, O. J., & Alper, B. (1970). *Halfway houses: Community centered correction and treatment*. Lexington, MA: Lexington Health Books.
- Link, B. G., & Cullin, F. T. (1983). Reconsidering the social rejection of ex-mental patients: Levels of attitudinal responses. *American Journal of Community Psychology*, 11(3), 261-273.
- Logan, J. R., & Molotch, H. (1987). *Urban fortunes: The political economy of place*. Berkeley: University of California Press.
- Ludlow, L. (1977, December 15). Fear and caring in Portola Heights. *The San Francisco Examiner*, pp. 1, 48, 50-51v.
- Marshall, P. G. (1989). Not in my back yard. *Editorial Research Reports*, 9, 306-309.

- O'Brien, D. (1975). *Neighborhood organization and interest group process*. Princeton: Princeton University Press.
- Orcutt, J. D., & Cairl, R. E. (1976). Neighborhood reaction to a community-based treatment center for alcoholics. *Journal of Studies on Alcohol*, 37(5), 619-631.
- Petrila, J., & Ayers, K. (1994). Enforcing the Fair Housing Amendments Act to benefit people with mental disability. *Hospital and Community Psychiatry*, 45(2), 156-160.
- Piasecki, J. (1975). *Community response to residential services for the psych-socially disabled: Preliminary results of a national survey*. Paper presented at the First International Conference of the International Association of Psycho-Social Rehabilitation Services. 15 November.
- Rabkin, Muhlin, J. G., & Cohen, P. (1984). What the neighbors think: Community attitudes toward local psychiatric facilities. *Community Mental Health Journal*, 20(4), 304-312.
- Raush, H. L., & Raush, C. L. (1968). *The halfway house movement: A search for sanity*. New York: Appleton Century Crofts.
- Segal, S. P., & Aviram, U. (1978). *The mentally ill in community based sheltered care: A study of community care and social integration*. New York: Wiley.
- Segal, S. P., & Kotler, P. (1989). Community residential care. In D. Rochefort (Ed.), *Mental health policy in the United States* (pp. 237-266). New York: Greenwood Press.
- Silverman, C. J., & Barton, S. E. (1994). Managing interdependence: The effects of neighboring style on neighborhood organization. In S. E. Barton & C. J. Silverman (Editors.), *Common interest developments: Private governments and the public interest* (pp. 169-192). Berkeley: Institute of Governmental Studies.
- Smith, C. J. (1981). Residential proximity and community acceptance of the mentally ill. *Journal of Operational Psychiatry*, 12(1), 2-12.
- Stickney, P. (Ed.). (1976). *Gaining community acceptance*. White Plains, NY: Community Residences Information Service Council.
- Suttles, G. (1970). *The social order of the slum: Ethnicity and territory in the inner city*. Chicago: University of Chicago Press.
- Taylor, S. M., Hall, G. B., Hughes, R. C., & Dear, M. J. (1984). Predicting community reaction to mental health facilities. *Journal of the American Planning Association*, 50(1), 36-47.
- Wahl, O. (1993). Community impact of group homes for mentally ill adults. *Community Mental Health Journal*, 29(3), 247-259.
- Warren, R., & Warren, D. (1977). *The neighborhood organizer's handbook*. Notre Dame: University of Notre Dame Press.
- Wenocur, S., & Belcher, J. R. (1990). Strategies for overcoming barriers to community based housing for the chronically mentally ill. *Community Mental Health Journal*, 26(4), 316-333.