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Urban and non-urban differences in community living and participation among individuals with serious mental illnesses

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ABSTRACT

Despite a wealth of studies examining the relationship between urbanicity (i.e., living in an urban area) and psychological distress, there is a paucity of research examining the relationship between urbanicity, community living, and community participation of adults with serious mental illnesses. This study addresses this knowledge gap by assessing urban and non-urban differences in community participation, sense of community, mental health stigma, and perceptions of the neighborhood environment among individuals with serious mental illnesses living independently throughout the United States. A total of 300 individuals with serious mental illnesses recruited from 21 outpatient mental health service organizations in 15 states completed a phone survey about their community living and participation experiences. Urbanicity was examined at two spatial scales (block group and county), and independent-samples t-tests were employed to assess urban and non-urban differences in community living and participation variables. Levels of community participation and perceptions of neighborhood quality and crime were higher in urban block groups; sense of community was higher in urban counties; and perceptions of mental health stigma were higher in non-urban counties. Results inform the methodological literature on best practices for assessing urbanicity, as well as interventions aimed at increasing community participation and improving aspects of the built and social environment that affect individuals who experience mental health distress.

The influence of urbanicity (i.e., living in an urban area; Vlahov and Galea, 2002) on mental health experiences has been a subject of focus since the seminal studies of Faris and Dunham (1939) in the United States and Hare (1956) in the United Kingdom, which demonstrated that the rate of schizophrenia was higher in urbanized areas compared to more rural areas. Similarly, the seminal work of Louis Wirth (1938) and Claude Fischer (1975) asserts that components of the urban environment (for example, stimuli such as noise, lights, and people) may increase social and psychological disorders. Finally, more recent work by Pedersen and Mortensen (2001) demonstrated a dose-response relationship between urbanization and schizophrenia risk, suggesting that this continues to be a fruitful and important area of research. Despite a wealth of studies examining the relationship between urbanicity and psychological distress, there is a paucity of research examining the relationship between urbanicity, community living, and community participation of adults with serious mental illnesses. This study addresses this knowledge gap by assessing urban and non-urban differences in community participation, sense of community, mental health stigma, and perceptions of the neighborhood environment among individuals with serious mental illnesses living independently throughout the United States. After a brief review of the historical and social context informing this study, we summarize previous research examining the relationships between urbanicity and our primary study variables and discuss our method for conceptualizing and assessing urbanicity. Study findings will inform interventions aimed at enhancing the ability of individuals with serious mental illnesses to live and participate fully in a variety of community contexts.

1. Historical and social context informing this study

Serious mental illness is a term used to classify persistent psychiatric conditions that can greatly affect a person's behavior,

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thinking, emotions, and relationships (Kloos, 2010). Diagnoses typically considered to be serious mental illnesses include schizophrenia, bipolar disorder, and severe and persistent depression. Historically, mental health treatment for individuals with serious mental illnesses often entailed removing them from their communities and warehousing them in large state-run psychiatric hospitals with infamously deplorable conditions. The Community Mental Health Act in 1963 heralded the onset of the deinstitutionalization movement, which aimed to end inhumane treatment in psychiatric institutions and restore individuals to life in communities (Carling, 1995). Unfortunately, the promise of this movement was never fully realized, and in the 21st century, the ideal of individuals with disabilities being fully integrated into their communities remains an unachieved goal (Kloos, 2010; Partington, 2005). There are a variety of reasons for this, perhaps the primary one being that individuals with disabilities have fewer opportunities to engage in their communities (White et al., 2010) and connect to the rights, responsibilities, roles, resources, and relationships that comprise what Michael Rowe and his colleagues refer to as *citizenship* (Rowe and Pelletier, 2012). Unaffordable or inaccessible housing, limited opportunities for employment, pervasive societal stigma, and lack of transportation severely limit involvement of individuals with disabilities. For example, 10% of people without disabilities compared to 30% of people with disabilities report transportation as a major problem (White et al., 2010). Individuals with serious mental illnesses are often reliant on the mental health system to provide transportation, particularly in rural areas where little public transportation exists (Priester et al., 2016). This severely limits individuals' ability to participate in activities— particularly normalized, self-initiated activities in the community. Next, we expand upon this discussion of environmental context, focusing on the impact of urbanicity on community living and participation of individuals with serious mental illnesses.

2. The relationship between urbanicity, community living, and community participation

Community participation. As noted by Ware et al. (2007), individuals with serious mental illnesses may be described as “in the community, but not of it” (p. 469). They often remain socially excluded with fewer opportunities for meaningful, self-directed participation in their communities (Ware et al., 2007). The World Health Organization (WHO) International Classification of Functioning Disability, and Health (ICF) has defined participation as a person's “involvement in life situations” (World Health Organization, 2001, p. 5), while others have defined it as “the involvement of the person in activities that provide interactions with others in the community” (Levasseur et al., 2015, p. 1718). Although very few studies have examined the relationship between urbanicity on community participation, some researchers suggest that participation may be more difficult for individuals with serious mental illnesses living in non-urban settings due to transportation barriers, higher levels of mental health stigma, and fewer community resources (McDonel et al., 1997). Research conducted among older adults in the general population suggests few differences in community participation across metropolitan, urban, and rural areas, although higher rates of participation in urban areas have been associated with greater proximity to neighborhood resources (Levasseur et al., 2015).

Sense of community. Sense of community has been linked to community participation (Chavis and Wandersman, 1990), psychological-well-being (Pretty et al., 1996), and life satisfaction (Prezza et al., 2001); and it represents the notion that one belongs to and is an integral part of a larger collectivity (Sarason, 1974). Sense of community has only recently started to be examined among individuals with serious mental illnesses, and primarily in the context of supported housing located in urban settings (e.g., Townley and Kloos, 2011). Research among individuals without disabilities suggests that rural and non-urban areas typically offer higher levels of sense of community (e.g., Romans et al., 2011), likely because lower population density encourages stronger connection and cohesion among residents (Ziersch et al., 2009). The current study will assess whether this finding also applies to individuals with serious mental illnesses.

Mental health stigma. Mental health stigma represents one of the strongest barriers to community inclusion and quality of life among individuals with serious mental illnesses (e.g., Corrigan et al., 2013; Prince and Prince, 2002). Individuals with disabilities have historically been devalued by society; and manifestations of mental health stigma can be seen in negative interactions with community members and also in disabling social structures, policies, and practices (Ware et al., 2007). Although the majority of stigma research has been conducted in urban settings, a few studies in rural settings highlight the potential relationship between urbanicity and perceptions of community tolerance for mental illness. For example, Stewart et al. (2015) examined internalized stigma, public stigma, and attitudes toward mental health care in a community sample of older adults living in rural and urban areas and found that older adults living in isolated rural counties reported higher levels of public and internalized stigma than those in urban areas. Further, the authors suggest that the large number of rural adults with untreated serious mental illnesses may indicate that stigma discourages individuals from seeking out mental health services. There are a variety of reasons that stigma may be higher in non-urban settings, but one of the most compelling rationales offered in the literature is that cohesive social relationships in rural settings may foster negative reactions to people with mental illnesses due to fears of anything different or “out of the ordinary” (Parr et al., 2004, p. 403). It is also likely that opportunities for relationships with individuals who share the experience of mental illness, which may help guard against the destructive effects of internalized stigma (Corrigan, 2006), are lower in non-urban spaces.

Perceptions of the neighborhood environment. While there has been an increase in research examining environmental influences on well-being, inclusion, and recovery among individuals with serious mental illnesses in recent years (Brusilovskiy and Salzer, 2012; Townley and Kloos, 2014; Yanos, 2007), studies have, again, occurred primarily in urban settings. Very few studies, if any, have directly compared aspects of the built and social environment between individuals with serious mental illnesses residing in urban and non-urban settings. It is likely that individuals in urban settings may have more positive perceptions of their physical environments compared to non-urban dwellers due to closer proximity to resources and enhanced access and walkability. However, research among individuals without disabilities suggests that residents of non-urban settings typically report stronger perceptions of safety and lower levels of perceived crimes compared to their urban-dwelling counterparts (Pain, 2000). These differences may be even more pronounced among individuals with serious mental illnesses, whose reports of safety-related concerns have been found to be as much as 70 percent higher than other urban-dwelling community members (Newman, 1994).

3. Study overview and approach to measuring urbanicity

In the context of a broader national study examining the impact of individual and environmental factors on community participation of adults with serious mental illnesses, we aim to examine the relationship between urbanicity and the community living and