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Beyond "Landscapes of Despair:" The Need for New Research on the Urban Environment, Sprawl, and the Community Integration of Persons with Severe Mental Illness

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Abstract

The purpose of this commentary is to discuss important trends in the housing of people with severe mental illness in the past 20 years that require the attention of mental health geographers and other experts on the effects of place on mental health. Issues that are worthy of consideration in new research include: assessing the impact of place effects on community integration, the impact of sprawl, and the emergence of the independent scatter-site housing model. Possible implications of these trends for the effects of place on people with severe mental illness are discussed.

In their ground-breaking work of mental health geography "Landscapes of Despair," Dear and Wolch (1987) documented how, in the aftermath of deinstitutionalization, people with mental illness had come to largely reside in "service-dependent ghettos" within North American cities. Even as they characterized the advantages and hazards of the concentration of people with mental illness in inner city environments, Dear and Wolch pointed toward a new trend that they saw emerging: the dismantling of the service-dependent ghetto in the wake of urban renewal, redevelopment and gentrification. Their work ended with a question mark regarding the degree to which these developments would lead to homelessness and would alter the ability of people with mental illness to live and function in the community.

In the nearly 20 years that have passed since the publication of "Landscapes of Despair," much has indeed occurred to significantly complicate the picture of housing among people with mental illness in North America. The purpose of this commentary is to encourage consideration of these developments among researchers interested in the effects of place on mental health, and discuss the need for new research examining the impact of these changes on the community integration of people with severe mental illness. While this commentary focuses on two relatively neglected areas (the impact of sprawl and the shift toward independent scatter-site housing), it should be noted that other important trends that have occurred in this area include the predominance of people with mental illness in other institutional settings such as homeless shelters and jails. Since these developments have received more attention (e.g., see Wolch and Philo's 2000review), this commentary will focus on areas that have been comparatively neglected in the mental health geography literature.

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Placing Community Integration on the Agenda

First and foremost, it is important that community integration be placed on the agenda of researchers who study the effects of place on people with mental illness. It is now widely agreed that services for persons diagnosed with severe mental illness should aim to facilitate community integration (Carling, 1995;Wong and Solomon, 2002). Recent reviews of the mental health geography literature (Philo, 2005;Wolch and Philo, 2000) suggest that mental health geography is beginning to move in the direction of studying the impact of place on the experience of "social inclusion and exclusion" among people with mental illness. However, with the exception of Pinfold's work (2000), an explicit link to the community integration construct and literature has not been made. In addition, some research has assumed a fairly dismissive tone with regard to the possibility that good community integration can occur in the urban environments where people with severe mental illness typically reside (Parr and Philo, 2004).

Though the construct of community integration has often been vaguely defined, Wong and Solomon (2002) recently clarified the construct by describing it as multidimensional, involving *physical*, *social* and *psychological* dimensions. The physical dimension involves "the extent to which an individual spends time, participates in activities, and uses goods and services in the community outside his/her home in a self-initiated manner;" the social dimension is closely related and consists of "the extent to which an individual engages in community interactions;" finally, the psychological aspect reflects the "extent to which an individual perceives membership in his/her community." Little is still known about what community, individual and program factors contribute to the successful community integration of this population (Wong and Solomon, 2002). However, as will be discussed, there are good reasons to believe that place may have a significant impact on community integration in all its forms.

The Trend Toward Increasing Sprawl in Congregate Housing

With the dismantling of the "service dependent ghetto" that Dear and Wolch (1987) described, the impact of sprawl becomes a concern. "Sprawl" describes a pattern of development characterized by low population density, high automobile dependence, and separation between housing, shopping and business districts (Frumkin, Frank, and Jackson, 2004). Though sprawl has existed to some extent since the invention of the automobile, and in truth rose up during the post-World War II housing boom, the last 25 years have seen a dramatic increase in sprawl throughout North America (Duany, Plater-Zyberk, and Speck, 2000).

Sprawl has been linked to a number of public health concerns, but, most importantly for the present discussion, is the presumed impact that sprawl has on people with disabilities, who may be largely excluded from the ability to fully participate in the community due to the structural barrier created by not being able to afford having and maintaining cars (Frumkin et al., 2004). Sprawl's impact on people with disabilities has been discussed in general terms, and has been the subject of little empirical assessment (for a recent exception examining the impact of sprawl on the elderly, see Clarke and George [2005]). The impact that sprawl can have on people with mental illness struggling to integrate into the community has yet to be explicitly discussed in the literature.

Why should the impact of sprawl on the community integration of people with mental illness be considered? As the revitalization of central urban areas has progressed in many North American regions, an emerging pattern in the congregate housing of people with mental illness is for housing settings to move to increasingly remote locations, either on the urban fringe where there is little access to the services of the urban core, or to new suburban settings that meet the objective criteria for sprawl. Evidence for this pattern was presented by a newspaper account of the concentration of state-licensed housing for people with mental illness in New

York City (Sanderson and Bulliet, 2006). Analyzing data from the New York State Office of Mental Health, the article observed that, as of 2000, neighborhoods on the urban fringe such Queens Village, College Point and the Central Rockaway's (in the borough of Queens) and Co-op City (in the Bronx) had higher numbers of state-licensed beds for persons with mental illness than the traditional "service dependent ghetto" districts of Harlem and Times Square in Manhattan. These settings presumably have been preferred for more recent housing to allow providers to take advantage of lower land prices, and provide protection from the "not in my backyard" syndrome since they tend to be removed from other residences.

Working in settings outside of the city in suburban New York and New Jersey, the author has observed that housing programs are sometimes even more remotely located, in areas that lack access to shopping services within walking distance and to public transportation altogether. Support for the view that congregate settings are now commonly located in suburban settings is found by analyzing the number of "board-and-care" facilities (excluding Residential Health Care Facilities, which primarily house the elderly, and drug treatment facilities), which house thousands of persons with severe mental illness in various counties in New Jersey (Board and Care New Jersey, 2006). A comparison of the two most urbanized counties in the state (Essex: 6,285.4 persons per square mile, and Hudson: 13,043.6 persons per square mile [US Census, 2006]) with 2 neighboring "suburban" counties (Morris: 1,002.6 persons per square mile, and Somerset: 976.4 persons per square mile [U.S. Census, 2006]) finds that while the two urbanized counties have 26 "board-and-care" facilities, the two suburban counties, with roughly half the population of the two more urbanized counties, still have 18 facilities. Many of these facilities are located far from town centers off of major thoroughfares with no sidewalks, and suggested by addresses such as "115 Route 206."

It is not difficult to imagine the potential impact that residence in "sprawled" congregate settings can have on the ability of people with severe mental illness to integrate into the community. If services are not located within walking distance (or walking to them would require walking on the side of roads with no sidewalks) and there is no access to public transportation, in order to be able to shop, attend health appointments, and participate in recreational activities, residents need to be "transported" via institutional vehicles. Reliance on this type of transportation can keep people with mental illness contained within a "virtual institution" and dictates that all their interactions with society will be supervised in some way. Several studies have discussed the importance that having access to parks, local food and shopping establishments has for people with mental illness in order to have the ability to feel comfortable living in the community (Beal et al., 2005;Knowles, 2000). In the community integration literature, use of shopping services and interaction with local community members is actually included in the definition of physical and social integration. The question becomes raised- how can one have integration when there are no local stores for one to make use of, or local residents to interact with? There is a need for explicit investigation of the impact of sprawl, as this will have important implications for the location of future housing facilities in an era when services claim to aim for "community integration" and "recovery" (Jacobsen, 2004).

The Move Toward Scatter-Site Independent Housing

Parallel to the development of locating congregate housing in increasingly remote areas has been the move away from congregate housing and toward scatter-site independent housing. Mental health consumers residing in independent scatter-site housing live alone in their own apartments located throughout the community where affordable units can be found. Services are typically off-site and there are considerably fewer program rules (Tsemberis and Eisenberg, 2000). Independent housing is designed to allow individuals to live in "normal" settings interspersed with general community members, and is intended to maximize opportunities to take advantage of natural local supports and resources (Ridgway and Zipple, 1990).

The prevalence of independent scatter-site housing varies by location, but there is evidence that it is becoming the predominant housing model for people with severe mental illness in North America. For example, in Robbins et al.'s, (2006)study of housing among 1,000 persons with severe mental illness presenting for outpatient treatment in 5 regionally disparate U.S. cities (Tampa, Worcester, San Francisco, Durham and Chicago), living in an independent apartment was the predominant type of housing (housing approximately 50% or more of the sample) in the 4 of the sites. Similarly, evidence of the growth of independent scatter-site housing in New York City is supported by data provided by the New York State Office of Mental Health "Patient Characteristics Survey" (New York State Office of Mental Health, 2006). Comparing data from the 1999 and 2003 surveys, it is found that the number of individuals living in independent scatter-site housing (classified as "supported housing" in the survey) in New York City increased from 2,359 to 4,207. Although the number of other types of housing units also increased during this period, the proportion of total units that were independent scatter-site increased from 31% in 1999 to 38% in 2003 (New York State Office of Mental Health, 2006).

An acknowledgement of the existence of independent scatter-site housing programs has not yet emerged in the mental health geography literature, which is still in large part concerned with the "post-asylum" congregate settings that arose in the wake of deinstitutionalization (Wolch and Philo, 2000). There are several reasons why mental health geography can enhance the field's understanding of the impact that residence in independent scatter-site housing has on community integration. First, there is the potential impact that neighborhood variables such as local social capital (Lochner, Kawachi, and Kennedy, 1999) and socioeconomic characteristics have on people with mental illness. Early research with individuals residing in group homes suggested that residing in communities with a predominance of political liberalism and an apparently healthy dose of social disorganization was associated with better community integration (as opposed to residing in more conservative, higher income, and well-organized working-class neighborhoods) among people with severe mental illness (Segal, Baumhol, and Moyles, 1980). However, it is not clear to what extent this was a byproduct of residence in the old "service dependent ghettos" where people with mental illness had a history of living, or if it was due to reduced community stigma in these types of settings.

Several community characteristics may be relevant that could be addressed in future studies. The study of social capital should be updated to address the contemporary understanding of "neighborhood factors," which has identified neighborhood collective efficacy, concentrated socioeconomic disadvantage, immigrant concentration and residential instability as neighborhood characteristics that are predictors of crime and health outcomes (Sampson, Raudenbush, and Earls, 1997;Browning and Cagney, 2002). These characteristics might also predict psychological community integration among people with mental illness. "Built environment" characteristics, such as the presence of graffiti, lack of recreation space, abandoned buildings, and environmental characteristics such as noise, and crowding, have also been found to be significant predictors of depressive symptoms in community samples (Weich et al., 2002; Halpern, 1995) and their impact should therefore be studied among people with severe mental illness, as depressive symptoms may be expected to impact psychological community integration, and fear of crime may impact social integration. The possibility that stigmatizing attitudes towards people with mental illness varies by neighborhood, and that variation in these attitudes can impact community integration (which Segal et al.'s [1980]; study implied) also needs to be explicitly examined. Some preliminary research has also suggested that the degree of "fit" between an individual with mental illness and the neighborhood where he or she finds housing, rather than any specific characteristics of the community per se, is the most important factor in determining community integration (Yanos, Barrow, and Tsemberis, 2004), but this hypothesis needs to be studied further.

An additional issue of concern is that the economic realities of independent scatter-site housing often dictate that many individuals with mental illness will move into areas that they have been previously unfamiliar with, and where they may lack family and other social support. Supporting this view is a recent analysis of the movement patterns of the population of persons residing in the province of Manitoba, Canada; this analysis indicated that people with severe mental illness were twice as likely as others to move to a different postal code within a three-year period (Lix et al., 2006). The reality of frequent movement raises concern that people with mental illness may experience “displacement” as they relocate to new settings. Studies of the psychology of “displacement” (Fullilove, 1996) suggest that relocation into unfamiliar settings can create a sense of loss and rootlessness. The process by which people with mental illness encounter and do (or do not) adjust to such displacement needs to be formally studied.

Conclusion

Important trends have been emerging in the housing of people with severe mental illness in the past 20 years that require the attention of mental health geographers and other experts on the effects of place on mental health. While in prior decades the field of mental health geography was on the cutting-edge of what was occurring in the lives of people with mental illness, the field has not have moved on from the study of “post-asylum” settings within the traditional urban “service dependent ghetto.” The purpose of this commentary has been to encourage consideration of important new trends that have been occurring in this area and suggest that future studies be conducted to address these discrepancies.

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