


Is It Safe? Community Integration for Individuals With Serious Mental Illnesses

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Abstract

Purpose: Community integration is a key component of recovery for individuals with serious mental illnesses (SMIs). The goal of the current study is to explore the nature and impact of safety concerns for experiences of communities for individuals with SMIs. **Method:** Using constructivist grounded theory, 30 semistructured interviews were analyzed to explore the depth and breadth of individuals' safety concerns, how individuals manage these concerns, and how these concerns shape their community experiences. **Findings:** Participants described various unsafe encounters related to neighborhood disorder, homelessness, traumatic experiences, substance use, stigma, and loss of relationships and multiple strategies to manage their safety. Many saw mental health services as a sanctuary from the dangers of their environment, providing support, resources, and coping skills. For many, future communities were envisioned within the context of safety. **Conclusions:** Service providers should consider safety as a critical issue that impacts how individuals experience their current and future communities.

Keywords

serious mental illnesses, community, safety, trauma, community mental health services

Community integration is well recognized as an important component of recovery for individuals with serious mental illnesses (SMIs), but it remains a persistent challenge for many (Pahwa et al., 2014; Townley et al., 2009). Post-deinstitutionalization, community integration services have been key components of mental health programs and policies (Farone, 2006) as there are many benefits to well-being associated with social inclusion (Townley et al., 2013). However, substantial barriers to successful community integration exist. Violence, victimization, and/or lack of perceived safety in the physical spaces where people spend most of their time can have a negative impact on community experiences of individuals with SMIs (Albers et al., 2018). Lack of belonging, social exclusion, and stigma are also known to adversely affect community experiences of individuals with SMIs (Bromley et al., 2013). The current study aims to explore the influence of stigma, lack of belonging, social exclusion, and threats to physical safety on the community experiences of individuals with SMIs in mental health services.

Physical Safety: Vulnerability to Violence and Victimization

Several studies have shown that individuals with SMIs have a higher likelihood of being the victims of crime and violence than those in the general population (Choe et al., 2008; Mangiglio, 2009). Individuals with SMIs are up to 11 times more likely to experience violent victimization including physical

assault, sexual assault, or threat of violence as compared to the general population (Christ et al., 2018). Furthermore, exposure to violence and victimization and a lack of physical safety have been associated with increased symptomatology, lower quality of life, and greater likelihood of revictimization for this population (Christ et al., 2018). Despite evidence of the impact of physical violence, victimization, and vulnerability on the experiences of successful community integration for individuals with SMIs, there has been minimal focus on these factors in community integration research.

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Psychological Safety: Belongingness, Perception of Safety, and Stigma

Psychological safety encapsulates feelings of safety, interpersonal trust, and respect (Vijayasingham et al., 2018), which enable individuals to feel a sense of belonging, acceptance, and affiliation for a community (Townley & Kloos, 2011). The presence of psychological safety has been linked to increased functional outcomes, life satisfaction, general wellness, and a more positive experience of community (Kloos & Townley, 2011). Conversely, a lack of psychological safety has been associated with social isolation, loneliness, alienation, and psychological distress (Townley & Kloos, 2011).

For individuals with SMIs, experiences of stigma and discrimination have insidious effects on factors related to feeling psychologically safe. Studies have shown that stigma also has a negative impact on community integration (Cabral et al., 2018). Research suggests even the anticipation of stigma can lead stigmatized individuals to avoid people or situations in the community that have the potential for rejection (Lundberg et al., 2013). Overt discrimination can interfere with important recovery goals such as employment, independent living, social connections, and overall wellness (Corrigan et al., 2010). Fear of potential discrimination and the related anxiety can also negatively influence people's willingness to be in a community or form close relationships (Pahwa & Kriegel, 2018; Pahwa et al., 2017), which can lead to social isolation, loneliness, loss of social skills, reduced social support, and social resources. Thus, for those with mental illnesses, fear of rejection may be just as important as the actual behaviors and attitudes of others for preventing them from initiating or feeling comfortable in social interactions.

Present Study

Existing research treats psychological and physical victimization as discrete and separate entities, at times overlooking the ways these experiences overlap and have reciprocal influences on experiences and behavior in communities and integration processes. Further, existing literature of violent victimization largely emphasizes why neighborhoods have increased crime but does not explain the processes by which people with SMI experience victimization and manage their safety experiences or how mental health services can influence this process. The present study will address this gap in the literature by examining how the confluence of neighborhood, relationships, and individual factors influence individuals with SMIs who are engaged in community mental health services as they navigate their safety within the community through the following three aims:

1. To describe the depth and breadth of safety concerns for individuals with SMIs within their communities and their relationships.
2. To examine how individuals manage their vulnerabilities to these safety experiences.
3. To explore how the participants' safety experiences and subsequent responses have shaped their interactions in the community and expectations for their future communities.

Method

Study Design

Data for this study were a part of a larger multisite project ($N = 90$) that aimed to understand how individuals with SMIs engaged in mental health services define and experience their communities (Pahwa et al., 2020; Smith et al., in press). The present study utilizes data from the Los Angeles project site ($N = 30$). Of the first 11 interviews of the overall project, safety and lack of safety was spontaneously mentioned by the first nine participants as an important component of their community experience, without any specific question on safety in our interview protocol. For example, some participants defined their community as a place where they felt safe. In response to these spontaneous discussions around community safety, the following questions were added to the protocol: "Please describe any safety issues in [name of community in interviewee's terms]," with subsequent prompts to explore past and present personal and neighborhood experiences. Notably, approximately half of participants at the Los Angeles site spontaneously discussed safety-related issues before being prompted with the safety question.

Using the constructivist grounded theory methodology (Charmaz, 2014), we aimed to set aside existing theoretical frameworks in order to avoid limiting analyses to prior theories, while being aware of and acknowledging our own worldview and biases to guide our analysis to a new understanding of violence and victimization. Grounded theory was the most apt strategy for this process since the conversation around safety emerged inductively from the participants during the course of our initial interviews and we did not use any existing theoretical frameworks to inform our analysis. Additionally, we used grounded theory methods to analyze our data using "constant comparisons" by which information from one individual is constantly compared with that given by the other participants to develop a theoretical framework to understand a construct (Padgett, 2016).

Study protocols were developed and refined with input from a Los Angeles Practice-Based Research Network called the Recovery-Oriented Care Collaborative. Internal Review Boards at New York University; University of Southern California; University of California, Los Angeles; and the Los Angeles County Department of Mental Health Human Subjects Research Committee approved the study protocols.

Sampling. Thirty in-depth semistructured interviews were conducted with adults with SMIs. Clinicians were asked to refer clients who had a diagnosis of schizophrenia spectrum disorder, bipolar disorder, or severe depressive disorder, and the participants were asked about their diagnosis as a part of the demographic interview. All participants were recruited from four community mental health agencies in the Greater Los Angeles area. Interviews explored their experiences of communities and community integration, including issues related to safety. Participants who met the inclusion criteria (English-

speaking adults with SMIs, 18 years or older, receiving services from the participating agency for at least 6 months) were recruited via posted fliers and agency providers. The study used a combination of theoretical and variation sampling to recruit participants. Consistent with the constructivist grounded theory methodology, theoretical sampling facilitated identification of communities, their experiences within their self-defined communities, and their safety experiences with the intent of reaching theoretical saturation (Sandelowski, 2008). Simultaneous use of variation sampling was used to obtain perspectives across a range of participant demographics (e.g., diagnosis, age range, and intensity of services received).

Measurement. Semistructured qualitative interviews focused on questions about individuals' perceptions of and experiences with different self-defined communities. The interviews began with a general question on their present life situation and followed up with questions like: "I'd like to ask you about your idea of a community" and "What does community mean to you?" In allowing participants to define these concepts, the interviewers were able to explore how participants both constructed and experienced communities on their own without imposing preexisting personal or theoretical constructs onto the data. At the end of the interviews, participants provided background information on their age, gender, race/ethnicity, marital status, employment, housing, mental health diagnosis, and length of mental health services with current agency.

Data collection procedure. After consenting, individuals participated in 60–180-min interviews in one session conducted between February and September 2018. The PI, along with a masters-level research assistant, interviewed all 30 participants (R.P. and R.D.). Interviews took place in a private office at agency sites. Participants were paid \$30 (USD) for participation. Interviews were audio-recorded, transcribed by an external transcription agency, and checked for accuracy by the members of the research team.

Analysis. Consistent with constructivist grounded theory processes, transcribed interviews were analyzed throughout the data collection process. ResearchTalks' "Think and Shift, Sort and Sift" approach (Maietta, 2006), which included diagramming, writing memos, creating individual participant episode profiles, and monitoring of community safety topics, was used for analysis to identify themes related to individuals' perceptions and experiences of different communities by the three coanalysts (R.P., R.D., and E.K.). The diagrams, memos, and episode profiles enabled the research team to develop a list of potential codes related to safety-related experiences and concerns. The codes were refined, defined, and converted into a codebook consisting of 18 subcodes subsumed under 15 main codes through constant engagement with the data. Research team members met regularly to discuss emerging topics across participant interviews. Throughout the analytic process, the three coders (R.P., R.D., and E.K.) engaged in constant comparison of the data by reviewing transcripts to search for

confirming or disconfirming information related to codes that led to the development of an initial codebook. During the monitoring of safety topics, the research team conducted line by line coding, which included a combination of descriptive, in vivo, and process codes (Saldaña, 2015). Each transcript was analyzed by a primary coder and a secondary coder using Dedoose Version 8.0.35 (2008).

We enhanced the rigor in the analytical process through multiple strategies (Creswell & Creswell, 2017). Throughout the data collection process, the interviewers wrote reflection and documentation memos discussing the experience of the interview. We also documented key quotations and discussions by participants that related back to the study research questions.

Findings

Participant Characteristics

On average, participants were 37 years of age ($SD = 13.81$). Thirty-three percentage ($N = 10$) of the sample identified as cisgender female, 63% ($N = 19$) as cisgender male, and 3% ($N = 1$) as a transgender woman. Two thirds of participants identified as a racial or ethnic minority. One third of the sample had children and 23% either had a job or volunteered. Two thirds of the sample received high-intensity case management and clinical services from the "full-service partnership (FSP) groups," while one third belonged to the wellness-based program "recovery, resilience, and reintegration." Please refer to Table 1 for demographic information. Participants will be referred to using pseudonyms.

Grounded theory analysis resulted in the emergence of three broad themes that represented participants' descriptions of their safety-related experiences: "encountering unsafe spaces," "securing safety," and "building safety and community." Within these themes, participants discussed various elements of their safety experiences. These themes and underlying elements are represented in the "navigating safety" model shown in Figure 1.

Navigating Safety

Perceived safety was a core concern for participants' experiences of their communities. Overall, 97% of the participants described at least one unsafe experience. To understand how these experiences related to community integration, we constructed a theoretical framework termed "navigating safety" that tracked how individuals' experiences influenced their interactions within communities and their subsequent reactions to those experiences. Within the "navigating safety framework," three themes appeared most salient for participants.

Encountering unsafe spaces. Safety was experienced as a complex, multifaceted issue that was influenced by neighborhood, community, and interpersonal contexts. Participants also described two overarching ways of feeling unsafe in their communities: "lack of physical safety" and "lack of psychological safety." Lack of physical safety, as described by the

Table 1. Sociodemographic Characteristics.

Sociodemographic characteristics	N (%)	Mean (SD)
Age (in years)		36.6 (13.81)
Gender		
Male	19 (63.3)	
Female	10 (33.3)	
Transgender	1 (3.3)	
Race		
African American/Black	13 (43.3)	
European American/White	9 (30)	
Latino	5 (16.6)	
Multiracial or Other	3 (10)	
Marital status		
Married	1 (3.3)	
Widowed	1 (3.3)	
Divorced	4 (13.3)	
Separated	2 (6.7)	
Never married	22 (73.4)	
Employment status		
Employed	8 (26.7)	
Unemployed	22 (73.3)	
Housing status		
Independent housing	5 (16.7)	
Provided by agency	17 (56.6)	
Other	8 (26.7)	
Service intensity level		
Full-service partnership (FSP)	20 (66.7)	
Recovery, resilience, and reintegration (RRR)	10 (33.3)	
Length of mental health services (in years)		3.3 (2.69)
Primary diagnosis ^a		
Schizophrenia spectrum disorders	16 (53.3)	
Bipolar disorder	8 (26.7)	
Major depression	11 (36.7)	

^aPercent totals exceed 100% because multiple diagnoses were reported.

participants, included acts of robbery, physical assault, abuse, sexual harassment, and interpersonal violence, as well as a broader awareness of community violence. These experiences included both the actual experiences of these acts and exposure to these acts (vicariously or as a witness). Lack of psychological safety encompassed acts of stigma, discrimination, and exclusion. Neighborhood and community contexts had significant impact on the experiences of participants and their perceived safety. Some common experiences regarding specific neighborhoods and perceived safety (e.g., Skid Row, South Los Angeles, and Long Beach) stemmed from witnessing, being in proximity to, or being a victim of crime or violence.

Lack of physical safety

Gang violence. Participants reported being aware of gang activity, which posed a challenge to their daily lives in their neighborhoods. Individuals reported the need for constant monitoring of their surroundings to detect the presence of gangs in order to limit their exposure to possible harm. Some participants noted a constant sense of vigilance to counter threats like racial tensions, gang activity, shootings, high rates

of crime, and even bomb threats. The pervasive presence of gang and police activity and/or emergency services indicated ongoing crime activity in their neighborhoods, leading to stress, hypervigilance, and constant safety monitoring. One multiracial female participant, Raina, described their neighborhood as “a lot of drama, fights, the police get called like a lot [*sic*]. There’s a lot of gang activity, there’s prostitution over there, there’s drugs . . . I don’t wanna go outside.”

Random acts of violence in public spaces. Other participants reported being victims of random acts of violence while homeless or using public transportation. These created lasting impressions of their living spaces, limiting their mobility. For example, after Ben, a White male participant reported being stabbed for singing on the bus, he stated:

I’m always looking around or you know looking everywhere because I’m nervous, especially after that. Is someone going to do it again or am I going to have another problem? So, I mean I only have to ride it when I have to.

Participants were particularly vulnerable while experiencing homelessness. For example, Juliana, a Latinx female participant, reported an assault while sleeping on a public beach at night. Emergency room staff’s disbelief of her story compounded the trauma:

[I was] beaten, raped and robbed when I was out on the street and I was partying. I ended up falling asleep on the beach thinking it was a safe place to sleep . . . two guys ended up coming in from behind . . . And then the next day I ended up going and driving myself to the hospital. So, I ended up having like this side of my head bashed in . . . All my arms and all my back was bruised, and I had rocks and debris lodged in my butt . . . but when I went to the hospital they didn’t do, they didn’t believe me. They didn’t do a rape kit; they didn’t do a police report. I didn’t know that I had to do a police report. I thought because I was in the hospital and I told them what happened that they would do a police report automatically. I ended up calling up Victims of Crime to get like reimbursed for some of the medical bills and stuff like that and they told me I wouldn’t be qualified because it was so late and I didn’t get a police report.

Interpersonal violence. Participants reported being exposed to physical violence in relationships with family and intimate partners, connected these experiences to becoming homeless, social isolation, or trauma, which in turn led to feeling unsafe, and further victimization. Victimization related to repeated acts of family violence was especially salient and problematic among transition age youth (TAY) participants who, due their age, relied on the same family members to provide support and resources. One participant became homeless after the uncle he lived with became physically violent toward him. Raina reported a desire to reconnect with her family despite violent outbursts from her mom: “My mom, she’s very physical so sometimes I have no choice but to defend myself because she’s attacking me.”

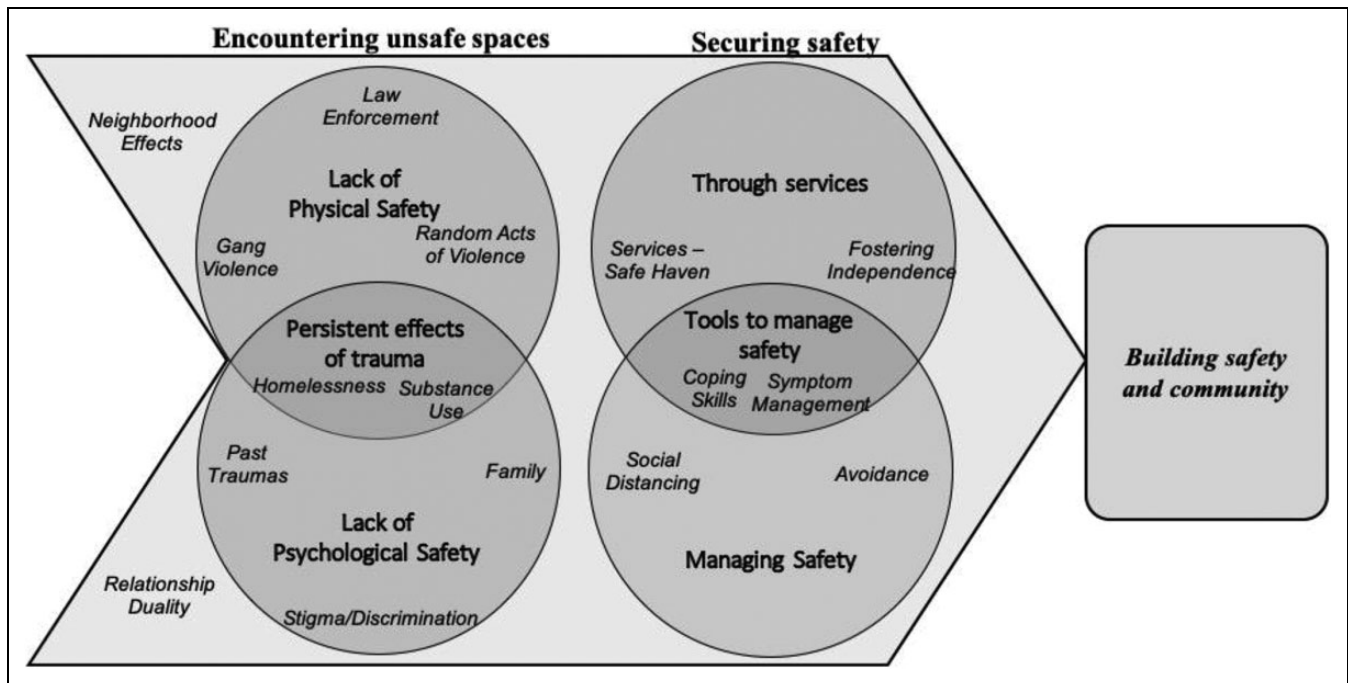


Figure 1. Navigating safety model.

Law enforcement. Some participants related feeling unsafe in the community due to a lack of support from various systems of care, including law enforcement. At times, people reported feeling abandoned by the police when they did not intervene in unsafe situations: “Like, the police are scared to go into the projects, you know?”—Michael. A few participants reported seeing law enforcement as perpetrators of physical and psychological victimization. Two participants discussed the role police played in their experiences in homelessness encampments. For Kate, a White participant, the police would locate and “display” to new recruits to demonstrate what a “typical” homeless drug user looked like. In another case, Michael, a Black male participant reported police failing to intervene when physical violence occurred in the encampment. He also talked about being profiled by the police due to their race or ethnic appearance: “you still get racial profiling, you still get judged, like police are still looking at us like, ‘What you doing over here? Well okay, you must be a criminal’.” Another participant, Dante, talked about being targeted by Immigrations and Customs Enforcement:

... two border patrol car [*sic*] came in and they’re like, “Put your hands up!” And like I put my hands up immediately because they have guns pointing at me and I just thought I was gonna die... I was a resident and I am a citizen... they were targeting [me] because I live in a predominantly Mexican minority community.

Lack of psychological safety

Past psychological traumas. Participants also described past traumatic events related to having a mental illness that contributed to currently feeling psychologically unsafe. Experiences

such as death or separation from family and loved ones, feelings of threat associated with homelessness, and overwhelming symptoms undermined their sense of psychological safety. Additionally, use of restraints during hospitalizations and feelings of abandonment by family as well as feelings of betrayal by the system were all described as problematic. Mary, a multi-racial female participant, associated hospital stays with helplessness: “I just feel like kinda like trapped cuz they like handcuff you to like the bed and then they like put you on an ambulance and then like they just like take you.”

Stigma. Participants reported personal encounters of stigma as well as witnessing it (e.g., overt stigma, general hostility, and incivility). This contributed to the overall sense that their neighborhoods and communities were unwelcoming places where they would be unable to form meaningful relationships. Often, stigma was described as a pervasive phenomenon that is inescapable and included perceptions that individuals with SMIs are dangerousness, as described by Matt: “I’ve had a few incidences on the train... where I started having a heated conversation with a hallucination. And I had the Sheriff called on me... So, it was a bitch.” He also noted that the presence of clinical symptoms marked him as dangerous in the eyes of others; thus, from then on, he perceived a need for constant monitoring of his own behavior so he could pass as not having a mental illness. Another White male participant, Jack, talked about discrimination after disclosing, their mental illness in a job interview: “I was in a job interview and they said, ‘Do you have any problems working in this certain kind of area?’ Once I explained about my illness they never called me back.” Additionally, witnessing stigma toward others with SMIs contributed to the general sense that their communities were hostile

toward those with mental illness and that concealing their mental health status was necessary for self-protection.

Across their social relationships and within social service agencies, participants also reported a range of discriminatory interactions related to their intersecting identities of race and ethnicity, gender, and sexual orientation. These experiences created lasting impressions that these relationships and contexts may not be safe; consequently, participants reported various strategies to minimize stigmatizing or harmful interactions. Participants described instances where experiences of stigma and discrimination from family members affected their recovery and trust in others. For example, while seeking advice from a trusted uncle, Dante was discouraged from pursuing a specific career path due to his mental health symptoms, which led to his withdrawal from college. Discrimination by family or communities due to other identities (e.g., sexual orientation) was also common. For example, Lexi became homeless after coming out as bisexual to her family and this disclosure of their sexual orientation was met with hostility and violent threats: “[My father] just didn’t accept me for who I was It was to the point where I had to remove myself away from him. Because he would make death threats.”

Family: A “double-edged sword”. Across interviews, participants expressed complicated relationships with their family members. For some participants, these relationships were a mixture of support, stigma, victimization, and other negative experiences. A Latinx male participant, Jorge, called his family a “double-edged sword” and referred to the relationship as toxic (a type of “quicksand”). He reported that his family had a history of alcoholism and described his mother as angry/irrational, sometimes making bad decisions. As a result, he periodically distanced himself physically and emotionally to protect himself from harm from his family. However, he circled back to them for support and resources when needed.

For many participants, support from family or social groups could be selective, completely unavailable, or inconsistent across people and/or time. Another Latinx male participant, Carlos, recounted finding supports from his immediate family, while simultaneously being let down by his extended family, “they just tell me to tough it out . . . then I just remember like how much they’re assholes, my dad’s side of the family to me.” Further, some participants had experiences where they felt services were weaponized against them (involuntary hospitalization) and did not trust their family members’ decision making regarding services. However, sometimes these shifting supports were in a positive direction, providing access to vital resources and encouragement for their recovery. For example, after requiring an initial 6-month period of sobriety, one White male participant, Henry, received housing and support from his grandma and subsequently adopted mutually beneficial caretaking roles.

Securing safety. Participants found multiple ways to secure their safety when encountering unsafe spaces by using the mental health service community as a safe space or by utilizing

different strategies to manage their safety. These strategies included adaptive survival tools they developed to manage different unsafe spaces and the tools they learned in services to manage their safety.

Security safety through services. Mental health services were an important source of safety and support. Participants talked about different ways that mental health services supported physical safety (against violence or victimization) and promoted psychological safety (buffering stigma and rejection). In some cases, there seemed to be an “onboarding process” where individuals took time to warm up to and trust their services. For others, there was an instant relief that they had entered services, particularly for people who were homeless and then secured housing through their mental health services. They talked about being very thankful for services, especially when they saw other people still on the streets and talked about how “You know, that could be me still”—Larry. Additionally, participants described and highly valued assistance in developing coping skills while in services to deal with and process past traumas. This included emotional regulation, managing stress, and developing impulse control that could help them avoid future harm, deal effectively with conflict, develop healthy social relationships, and increase community participation.

Participants also talked about mental health services fostering their independence and applying the learned life skills for daily self-care, in order to take charge of their own lives. As one Latinx female participant, Erica, talked about her *harm reduction* group:

And right there they teach us . . . how to handle your triggers. Or if there’s confrontation . . . how we don’t want to be going back to homeless . . . how we have to take care of our unit and pay our rent.

Participants also talked about the mental health services as a “safe haven” against the lack of physical safety and stigma in the general community. As one White male participant, Matt outlined:

[I]t’d be easier to get yourself into trouble outside So, that’s why I feel safer here than when I go outside You always have to be aware of what you’re doing, and what everybody’s doing—you never know who you’re going to run into.

Erica, when asked about her wellness center, talked about it as her “sanctuary” and as a place where he can “let all problems go.” Participants also discussed a sense of psychological safety and relief derived from relationships with providers and peers where they could exist free of judgment, persecution, or exclusion. Even though they are discouraged from doing so, some participants talked about how their mental health providers have replaced their family:

I guess they frown on that for whatever reason I don’t really know I call a lot of people, a lot of the employees here my friends . . . because you’ve done so much for me that it just seems like a natural process that you would become my friend.—Matt

Beyond the service providers, participants talked about a sense of connection, common identity, and a sense of belonging with other mental health peers that enabled them to support each other. Because others were aware of their diagnosis, participants “[didn’t] feel that you’re being judged” or “have to pretend” or “play along with the rules of society”—Henry. Other participants talked about developing friendships based on these shared experiences, which seemed harder to get from individuals without lived experiences of mental illness. “People really don’t understand it unless they have it . . . the first thing people hear when you hear mental illness, they’re crazy people, the homeless people off the street yelling at the sky”—Lexi.

However, not all aspects of the mental health community were considered safe. Some participants identified instances where they felt unsafe with their mental health service communities and in their agency-provided housing. Others indicated being wary of other clients due to their unpredictable symptoms or described challenges with other residents in their housing who were seen as threats to their physical safety or recovery from substance use. For example, Erica, living in agency-provided housing, was concerned for her safety due to “a neighbor that sometimes wakes up in a bad mood and decides to be yelling up and down the, our corridor, you know, at the top of his lungs and screaming and everything and making noise.”

Managing safety. We found that participants developed strategies to cope with an unsafe environment to manage their safety proactively. These strategies ranged from identifying and recognizing their triggers, using existing tools to manage symptoms, and/or avoiding physically unsafe locations and psychologically unsafe relationships. Other participants described strategies such as seeking appropriate services, self-talk to deescalate stressful situations, managing anger, mania, psychosis, and medication compliance.

Many participants described learning to avoid people or situations where they might have to interact with gangs (e.g., avoiding certain neighborhoods or limiting the times of day that they are out in the community). For example, a Black male participant, Robert stated:

I really didn’t talk to the people over there very much . . . ‘cause there’s gangbanging over there. I’d just like, “Hi,” and go on in the house . . . ‘cause I didn’t want to get caught up in no kind of drama.

A few participants talked about building relationships with gang members for protection, but more often people described gangs as limiting their mobility within the community. Some participants talked about developing protective skills when they were homeless by not sleeping alone, always finding a buddy to make sure that they had a backup and trying to be friendly to people to avoid issues. Several participants applied these strategies to manage safety in their current circumstances, even if those dangers were less salient. For example, a previously homeless participant, Michael, still maintained vigilance around his surroundings and used the skills necessary to

survive in unsafe neighborhoods like not wearing gang-affiliated colors or not walking on certain streets. Many women in our study practiced being extra vigilant in their surroundings and using strategies to manage their safety like avoiding going out after dark and avoiding certain people. This was especially true for women who also identified living in high crime neighborhoods. For example, Raina stated: “I don’t go anywhere after it gets dark . . . that’s when it gets super shady. I kinda get what I gotta do during the daytime so I’m back before all the craziness starts.”

Many participants had other ways of securing safety, including social distancing. This was especially true for people who didn’t feel safe in the context of their mental health services and some who refused to be involved in services past the minimum required amount. For example, a White female TAY participant, Jessica, who felt constantly let down by the government social systems and felt that her board and care facility wasn’t a particularly safe space, talked about feeling overwhelmed in social spaces, and not really feeling connected to anyone: “I just have a strong dislike of people. I don’t see them as like beneficial.” A number of participants reported how South Los Angeles is “kinda scary” and there are people getting shot in their neighborhoods. These dangers might be the biggest barrier to them establishing supportive relationships in their communities, yet distancing oneself from unsafe situations was seen as the best self-protection, as stated by Erica:

Around here I don’t really like to spend time with anybody just because I don’t feel safe. I think it’s better to be alone in an area like [this] because you never know what the other person might be thinking or going through that day.

While some social distancing seemed to be a barrier in getting close to people or forming new social connections and developing a sense of community, not all social distancing was problematic. Some of the social distancing was adopted as a protective factor against threats like substance use. When asked about people they no longer hang out with, participants talked about distancing themselves from people who still used drugs and alcohol. Participants also talked about managing stigma by being selective about to whom and to what extent they disclosed their mental illness to protect themselves against being judged or other unexpected reactions.

Building safety and community. Participants often described their goals, hopes, and visions of a meaningful and desired community as shaped by their previous unsafe experiences. For instance, some individuals, who were deeply impacted by their past traumas and lack of physical safety in their lives, thought of their future in the context of finding physical safety as illustrated by the following Black male participant, Dex:

I used to be in the streets. I used to sleep on the curb. I was in the gutter. I was on the sidewalk. I was on the ground. So, when I stood up to dust myself off I told myself I’m not going back there no

more . . . I'm going straight up. That mean[s] I want to reach a goal. That means I'm going up the ladder.

Other participants, after finally finding safety, talk about doing everything they can to keep it, as stated by a White male participant, Larry:

What I would like, is mostly just peaceful, nonviolent . . . because the violence . . . I've experienced some of it . . . that bothers me. So that's my community, you know? There's a lot of happiness.

Some talked about their future communities as places that were "positive" and "family-friendly . . . where kids can go outside and play and you don't have to worry about them getting hit by a stray bullet," as stated by Michael.

Still other participants talked about building safety in relationships and communities by contributing to others and finding opportunities to give back. Juliana indicated that she would like to help others by sharing what she has learned through achieving sobriety, noting that it is important to give back in service and helping the people. Another participant, Chuck, described his vision of building and engaging in community as a means of having a positive impact on others, thereby giving his life value and purpose. He stated that his hope after his death would be that others would be able to reflect on his impact upon them by concluding "that man right there has helped me."

Directly contrasting stigmatizing experiences, participants discussed their goals and hopes regarding their notions of community as a place of acceptance and positive regard. Larry described his wish for a community that is "respectful, peaceful, and caring" as well as a place where he gains a sense of positive regard such as being recognized and acknowledged by local shop owners. This notion of community as an environment that facilitates a feeling of acceptance and regard is echoed by Ben who describes the ideal community as a "place that likes you because you're you . . . someplace that doesn't judge you pretty much."

Several participants discussed notions of community in terms of their desire to be productive, which they associated with the ability to function independently rather than being reliant upon others. For these individuals, being part of a community was associated with "paying taxes" and not being dependent on the government or mental health service providers, implying a wish to find a sense of belongingness and psychological safety in the mainstream community. They described a wish to "transition back to normal life society." Some participants conceptualized the notion of generally positive experiences, information, and learning gained through the mental health community to contexts outside this environment. For example, Larry expressed the idea or hope that learnings gained through the Wellness Center served to sustain him when he was at home. These participants can be contrasted with those who wished to remain connected to their mental health communities, emphasizing that the provider community would be "difficult to replace" and that "sometimes, you're incurable."

These participants felt a sense of psychological safety in the mental health service communities.

Lastly, some participants expressed the hope to have a stable economic future and to build new relationships as a basis for their future communities. Participants expressed hopes that they will be able to meet their basic needs, have a romantic partner, start a family, or develop new friendships in the future. For example, a Black female participant, Charlene stated:

I would have really strong stability, meaning that I wouldn't have to worry about being homeless again and I wouldn't have to worry about my living situation or money or just basic necessities and maybe actually have a few friends.

Hope for a better future such as these reflected the sense of a physically and psychologically safe future.

Discussion

Our findings led to a grounded theory framework of *navigating safety* that describes (1) how people receiving mental health services are exposed to various forms of physical and psychological victimization in unsafe spaces, (2) the strategies they use to cope with and manage these encounters, and (3) the ways these experiences and strategies interact to influence conceptualization of future communities and safety. While the study used grounded theory methods and as such did not use an existing framework for analysis or organization of results, our findings were closely aligned with the social disorganization theory (SDT), which posits that adverse neighborhood characteristics (e.g., poverty, residential instability, ethnic heterogeneity, and weak social networks) lead to decreased social control and increased crime with this relationship being mediated by informal control, social ties, social capital, and collective efficacy (Kubrin & Weitzer, 2003). Developing a better understanding of the experiences and the strategies used by those with SMIs to navigate their safety across multiple life dimensions (e.g., neighborhood, past trauma, interpersonal relationships, and service usage) can help providers to improve community integration interventions.

Neighborhoods and Safety

The participants in our study were subject to stressors related to low socioeconomic status (SES) including residing in low SES neighborhoods (e.g., South Los Angeles, Skid Row, and Long Beach). Participants in this study expressed well-founded concerns about their safety in high-risk neighborhoods, which is consistent with the SDT. Accordingly, safety or the lack thereof was extremely important for participants who reported experiencing an array of violence, victimization, and stigmatizing experiences (Christ et al., 2018). For many participants, neighborhoods had high levels of gang violence, which had direct and indirect impacts on their safety experiences as they strategized whether to befriend or avoid contacts with gang members and areas. Befriending gang members can be a way of finding

support and increasing social engagement (Hartwell & Benson, 2007), but it is also associated with risk factors that can perpetuate victimization and engagement in violent behavior (Estrada et al., 2018). These tensions put individuals in a double bind, forcing them to either choose social connection (and risk harm) or isolate themselves to prioritize their safety. These instances lead to coping mechanisms like avoidance and distancing, which increased their vulnerability for social isolation.

Related to their low SES, participants were often subject to experiencing a higher volume of daily hassles and adverse social interactions that contributed to their safety concerns in the community. For example, most participants did not have access to a personal vehicle and were reliant on public transportation. Several participants witnessed or personally experienced adverse interactions on public transit. Participants describe a heightened awareness of their mental health status while in these spaces, particularly due to frequent stigmatizing experiences such as encounters with strangers on public transportation and law enforcement who considered them violent or unpredictable. These experiences and resulting feelings of stigma could deter them from using public transportation and limit their access to various community activities and community engagement. Stigma was also a primary cause for a perceived lack of psychological safety. These findings are also consistent with the general strain theory which posits that stressors (1) prevent people from achieving desired goals, (2) remove valued stimuli, or (3) expose individuals to noxious stimuli can lead to maladaptive coping responses (Agnew & White, 1992). The strains that individuals with SMI have to manage due to their adverse experiences in public spaces contributed to their desire to escape or distance from their communities.

Safety and Intersectionality

For individuals with SMIs, intersecting identities such as race, gender, and mental health status can impact and directly lead to experiences of stigma and victimization (Oexle & Corrigan, 2018). As such findings from the current study can be interpreted within the context of intersectionality theory (Crenshaw, 1990) that takes into consideration the impact of intersecting identities and how factors such as structural racism, sexism, xenophobia, and mental health status may impact experiences of safety, violence, and victimization. For the predominantly racial/ethnic minority individuals in our study, both race and gender emerged as an important contextual factor in their safety-related experiences.

Several participants discussed safety concerns related to being racially/ethnically profiled and targeted due to their skin color suggesting unique experiences related to racism and xenophobia that negatively impacted safety-related experiences. Other participants of color discussed visions of a future that was safe from multiple risks, such as community violence and economic insecurities issues, which are intimately related to larger systemic issues such as structural racism and discrimination (Rothstein, 2017). This is consistent with recent

literature that focuses on the experiences of racial/ethnic minority individuals with SMIs. For example, Smith et al. (2019) recently found that sociocultural context and the intersection of multiple stigmatized identities impacted the experiences of victimization in a predominantly Black sample of individuals with SMIs living in an urban city.

Multiple women, most of whom were women of color, talked about being extra vigilant about their safety, taking steps to reduce risk of sexually violent victimization and/or were victims of sexual violence. These experiences are consistent with recent research that has demonstrated how gender and mental illness intersect to impact increased rates of sexual violence for females with SMIs compared to both males and females without an SMI (Latalova et al., 2014). Existing research, coupled with the experiences of participants in our study, speaks to the intersection and unique safety-related risks that women of color with SMIs may experience, especially those living in neighborhoods plagued with structural violence.

Persistent Effects of Trauma

People's perceptions of safety were not just informed by their present circumstances but were reflective of past traumatic and stressful life events. Clinical symptoms, traumatic events and losses, homelessness, and substance use interacted in ways that made it difficult for them to trust themselves or to process their experiences well. Participants discussed how traumas associated with their mental illnesses and substance use impacted their current safety experiences. This is consistent with existing literature, which demonstrates that past traumas adversely affect the physical, mental, and emotional health of adults even years after the traumatic incident occurred (Sweeney et al., 2018). Additionally, our participants talked about exposure to multiple traumas and stressful life events known to have cumulatively harmful effects on physical and mental health. For example, in a study with two nationally representative samples from the United States and the UK, Shevlin et al. (2007) found that multiple traumas, such as childhood physical and sexual abuse, significantly predicted psychosis.

Relationship Duality

Participants discussed dualities of their relationships with immediate and extended family members, friends, and other important social relationships. Navigating these relationships required balancing their need for support, resources, and safety with their need to protect themselves from harmful interactions. For example, families sometimes serve as an important source of support in the lives of individuals with SMIs while simultaneously being sources of stigma, rejection, violence, and victimization (Perese, 2007). Although family members are the most frequent targets for violence by those with SMIs, they are also the most likely to victimize a family member with an SMI (Cascardi et al., 1996).

Family may have difficulty understanding or accepting mental health issues of the family member with SMI or the

need for services (Padgett et al., 2008). This may result in families failing to accommodate the psychological needs of a family member with an SMI or being overtly hostile toward their mental health identity or psychological symptoms (Guada et al., 2009). Mental illness can often be a heavy burden for a family to bear (Bradshaw et al., 2007). Caregivers who convey to family members with mental illnesses that they are considered a burden may increase the family member's sensitivity to stigmatizing experiences (Phelan et al., 1998). People respond to these experiences in a variety of ways, some use substances, run away from home, or avoid others (Miller & Major, 2000). Learning how to negotiate those relationships may be key to their long-term relational health within and beyond their families. For instance, avoiding peers who still engage in substance use to preserve their recovery (Padgett et al., 2008; Pahwa et al., 2019) or termination of relationships with particular family members when that relationship is toxic (Bradshaw et al., 2007). Clients find themselves balancing these decisions with the possibility that whatever they choose may result in compromising access to basic resources, such as housing, further increasing participants' likelihood of adverse outcomes (e.g., homelessness or living in a dangerous neighborhood).

Mental Health Communities and Safety

Participants talked about leveraging their mental health community to deal with the deficits of physical and psychological safety. These services were sometimes also seen as a "sanctuary" that demonstrated the possibility for safety in their lives. A study by Chan (2018) emphasized the importance of mental health community-based permanent supportive housing providing a "safe space," ontological security, connection to daily routines, community activities, and a sense of independence. Participants in that study also identified social connections with housing staff, case managers, and mental health peers as "safe people." In the current sample, all the participants had been receiving mental health services for at least 6 months and the majority had been in mental health services for many years. As this was a treatment-engaged sample, it is not surprising that they often reported positive feelings and attachment to their mental health community. Further, linkage to lifesaving services (housing, healthcare, benefit) can improve their quality of living, meet basic needs, and increase their physical safety.

Past and present victimization experiences, in conjunction with the strategies used to manage their safety, heavily informed future vision of clients' safety as well as their approach to achieving these ideals. For instance, people who had extensive trauma histories often visualized their future community as somewhere safe, peaceful, and secure. People who have been positively influenced by their mental health community and had formed new relationships in these communities talked about "giving back" or being there for others as an integral part of their futures. However, this finding should be interpreted with caution, as perceived stigma from the mainstream community is associated with greater attachment to the

mental health services community (Pahwa & Kriegel, 2018; Pahwa et al., 2019). As a result, some participants may be unwilling to seek communities beyond that experienced within mental health settings, which may increase social isolation that requires professional intervention from providers (Bromley et al., 2013). Additionally, despite many participants reporting that their mental health community was welcoming and provided necessary emotional and instrumental support, not all participants reported positive feelings about all aspects of their mental health communities, expressing feeling unsafe due to the behavior of other peers or specific instances that posed risk at their mental health service agencies.

Implications

Pending further investigation with a larger sample size, findings from this study indicate important implications for changing practice behavior in community mental health services, mental health policy, and future research examining strategies to address unsafe and traumatic experiences as well as for improving community integration among people with SMIs. Mental health service recipients in this study had significant experiences of victimization and lack of safety stemming from a range of multidimensional factors such as living in unsafe and high-risk neighborhoods, physical and sexual abuse, societal stigma, and social rejection. Such widespread experiences of lack of safety and trauma suggest that mental health service administrators and providers be prepared to adapt protocols and interventions to address these issues among people with SMIs.

Implications Related to Mental Health Services

Assessment. Mental health services for those with SMIs must be embedded within a framework of culturally responsive trauma-informed care, guided by accurate assessment of physical and psychological violence, and tailored to clients' specific history of unsafe experiences within relationships and in the community. Perceived as intrusive, distress-inducing, or potentially damaging to the therapeutic alliance, providers may avoid in-depth discussion around victimization and trauma. Currently, there is a paucity of protocols designated for mental health providers to systematically examine a range of such trauma-related experiences (Zammit et al., 2018). Findings from this study may be used to guide the development of such a multidimensional protocol for assessing and examining unsafe experiences as well as delineating existing coping strategies and resources to build upon and expand clients' sense of safety, belonging, and community. Participants in this study talked about past as well as current trauma-related events and environments on a macro-, mezzo-, and micro-level, suggesting the use of a social-ecological framework (Stokols, 1996) to inform assessment. For example, providers may assess macro-level domains (societal stigma related to housing or employment discrimination), mezzo-level domains (neighborhood safety with such indicators as gun violence, gang activity and police surveillance), and microlevel domains (violent or abusive

interpersonal relationships) that impact a client's ability to secure safe housing and employment, increase social functioning, and experience a better quality of life.

Reframing coping strategies. Utilization of psychoeducation within a strengths-based perspective may guide the identification of coping strategies and behavioral responses that, if reframed and used as resourceful, self-protective strategies, can protect against the repetition of unsafe, rejecting, or traumatic experiences. For example, clients may be educated to draw links between past and current physical and psychological violence and psychiatric symptoms, substance use, and social functioning difficulties. By understanding a variety of symptoms and behaviors as adaptations to painful circumstances, individuals may be able to identify more intentional and constructive coping mechanisms as well as altering negative views and beliefs about themselves as being personally deficient or deviant.

Policy and Program Implications

There are significant safety-related challenges associated with the lack of available safe and affordable housing for people with SMI necessitating policy-level intervention (O'Hara, 2007). Findings from this study that point toward widespread and significant trauma associated with neighborhood violence, homelessness, and housing insecurity among individuals with SMIs suggest that affordable housing and supportive services aimed at helping consumers retain housing must be a priority at the federal, state, and local level. Access to safe and affordable housing overall has been hampered by ongoing cutbacks in federal housing funds over the last several years. Further, lack of accompanying support services that enable those with SMI to maintain housing has increased the likelihood of them cycling between jails, institutions, and homelessness (Barrenger & Canada, 2014).

Along with the need for expanded access to affordable housing resources, evidence-based practices and service delivery models designed to reduce risk of homelessness and improve housing options for clients can mitigate unsafe experiences in the community for people with SMIs. Ensuring that community mental health service teams are trained and funded to work exclusively on meeting clients' housing needs is critical. Ideally, clients can be provided with a variety of housing options, allowing them to choose the neighborhood and living situation that feels most safe.

Research Implications

Findings from this investigation have several important implications for areas of future study. For example, studies may examine the feasibility and preliminary promise of social-ecological framed community-safety assessment protocols and psychoeducational interventions such as the ones described above. Training interventions could also be evaluated in terms of their impact on improving staff knowledge, confidence, and

skills in talking to clients about these multifaceted safety-related experiences. Ultimately, further research is needed to help determine whether such protocols are related to important service outcomes for people with SMIs, such as increased levels of community integration, psychological belonging, social functioning (e.g., size and quality of social networks), and other quality of life-related indices (e.g., housing and community tenure).

Limitations

Our study was cross-sectional and did not capture changes in perceptions and experiences of safety over time. Our study only sampled participants who were actively enrolled and participating in services. Therefore, these findings do not account for the lack of safety of individuals with SMIs who are not enrolled in services and might have very different experiences related to managing and building safety. However, participants did discuss past experiences related to safety concerns prior to receiving services. Our study included individuals living in urban neighborhoods and did not explore experiences of safety within rural populations, which may limit their generalizability to rural and suburban settings. It is important to note that qualitative research is designed to maximize in-depth understanding of concepts and the development of theoretical models rather than generalizability, as was the goal of this study. Future research with representative samples using quantitative methods may explore the generalizability of these findings. Notwithstanding these limitations, the current study provides new insight on the extent to which this population faces unsafe spaces, the strategies they use to manage safety, and how these encounters influence their current experiences within communities and hopes for future experiences within communities. While much of the literature in SMI and safety focuses on the mental illness identity, this current work moves beyond the singular focus on mental illness identity to include larger sociocultural issues impacting the lives of individuals with SMI. Neighborhood and community safety, poverty, complicated interpersonal relationships, and past and present traumas were all explored to draw a more nuanced, complicated, and layered theoretical model that accounts for lack of safety at multiple levels.

Conclusions

Mental health services have limited resources to protect individuals with SMI from all possible harm. Nonetheless, safety is a critical issue to address and it can be a challenge to consider how to prevent or manage all threats within the communities that individuals reside. The current study highlights the importance of mental health services in helping participants manage their safety and at times, providing respite from the stigma and lack of safety in the outside world. Future research should test the validity and reliability of the *navigating safety model* for a larger sample size of individuals in services and for individuals with SMIs who have not entered services and confirm these findings in other contexts (e.g., rural).

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References

- Agnew, R., & White, H. R. (1992). An empirical test of general strain theory. *Criminology*, 30(4), 475–500. <https://doi.org/10.1111/j.1745-9125.1992.tb01113.x>
- Albers, W. M., Roeg, D. P., Nijssen, Y., Bongers, I. M., & van Weeghel, J. (2018). Effectiveness of an intervention for managing victimization risks related to societal participation for persons with severe mental illness: A cluster RCT study protocol. *BMC Psychiatry*, 18, Article 247. <https://doi.org/10.1186/s12888-018-1831-7>
- Barrenger, S. L., & Canada, K. E. (2014, May 4). Mental illness along the criminal justice continuum. *Journal of Forensic Social Work*, 4(2), 123–149. <https://doi.org/10.1080/1936928X.2014.948251>
- Bradshaw, W., Armour, M. P., & Roseborough, D. (2007). Finding a place in the world: The experience of recovery from severe mental illness. *Qualitative Social Work*, 6(1), 27–47. <https://doi.org/10.1177/1473325007074164>
- Bromley, E., Gabrielian, S., Brekke, B., Pahwa, R., Daly, K. A., Brekke, J. S., & Braslow, J. T. (2013). Experiencing community: Perspectives of individuals diagnosed as having serious mental illness. *Psychiatric Services*, 64(7), 672–679. <https://doi.org/10.1176/appi.ps.201200235>
- Cabral, J., Carvalho, C. B., da Motta, C., & Sousa, M. (2018). Validation of the community integration scale for adults with psychiatric disorders (CIS-APP-34). *Community Mental Health Journal*, 54(5), 673–681. <https://doi.org/10.1007/s10597-017-0228-2>
- Cascardi, M., Mueser, K. T., DeGiralomo, J., & Murrin, M. (1996). Physical aggression against psychiatric inpatients by family members and partners. *Psychiatric Services*, 47(5), 531–533. <https://doi.org/10.1176/ps.47.5.531>
- Chan, D. V. (2018). Safe spaces, agency, and connections to “regular stuff”: What makes permanent supportive housing feel like “home.” *Rehabilitation Counseling Bulletin*, 63(2), 102–114. <https://doi.org/10.1177/0034355218814927>
- Charmaz, K. (2014). *Constructing grounded theory*. Sage.
- Choe, J. Y., Teplin, L. A., & Abram, K. M. (2008). Perpetration of violence, violent victimization, and severe mental illness: Balancing public health concerns. *Psychiatric Services*, 59(2), 153–164.
- Christ, C., de Waal, M. M., van Schaik, D. J., Kikkert, M. J., Blankers, M., Bockting, C. L., Beekman, A. T., & Dekker, J. J. (2018). Prevention of violent revictimization in depressed patients with an add-on internet-based emotion regulation training (iERT): Study protocol for a multicenter randomized controlled trial. *BMC Psychiatry*, 18(1), Article 29. <https://doi.org/10.1186/s12888-018-1612-3>
- Corrigan, P. W., Morris, S., Larson, J., Rafacz, J., Wassel, A., Michaels, P., Wilkniss, S., Batia, K., & Rüsche, N. (2010). Self-stigma and coming out about one’s mental illness. *Journal of Community Psychology*, 38(3), 259–275. <https://doi.org/10.1002/jcop.20363>
- Crenshaw, K. (1990). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241–1299.
- Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage.
- Dedoose Version 8.0.35. (2008). *w. a. f. m., analyzing, and presenting qualitative and mixed method research data*. SocioCultural Research Consultants. www.dedoose.com
- Estrada, J. N., Huerta, A. H., Hernandez, E., Hernandez, R., & Kim, S. (2018). Socio-ecological risk and protective factors for youth gang involvement. In H. Shapiro (Ed.), *The Wiley handbook of violence in education: Forms, factors, and preventions* (pp. 185–202). Wiley-Blackwell.
- Farone, D. W. (2006). Schizophrenia, community integration, and recovery: Implications for social work practice. *Social Work in Mental Health*, 4(4), 21–36.
- Guada, J., Brekke, J. S., Floyd, R., & Barbour, J. (2009). The relationships among perceived criticism, family contact, and consumer clinical and psychosocial functioning for African-American consumers with schizophrenia. *Community Mental Health Journal*, 45(2), 106–116. <https://doi.org/10.1007/s10597-008-9165-4>
- Hartwell, S. W., & Benson, P. R. (2007). Social integration: A conceptual overview and two case studies. In W. R. Avison, J. D. McLeod, & B. A. Pescosolido (Eds.), *Mental health, social mirror* (pp. 329–353). Springer.
- Kloos, B., & Townley, G. (2011). Investigating the relationship between neighborhood experiences and psychiatric distress for individuals with serious mental illness. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(2), 105–116. <https://doi.org/10.1007/s10488-010-0307-y>
- Kubrin, C. E., & Weitzer, R. (2003). New directions in social disorganization theory. *Journal of Research in Crime and Delinquency*, 40(4), 374–402.
- Latalova, K., Kamaradova, D., & Prasko, J. (2014). Violent victimization of adult patients with severe mental illness: A systematic review. *Neuropsychiatric Disease and Treatment*, 10, 1925–1939.

- Lundberg, B., Lundqvist, P., Hansson, L., Wentz, E., & Sivberg, B. (2013). Experiences of rejection by mental health patients—A qualitative study. *Health, 5*(10), 1553–1560. <https://doi.org/10.4236/health.2013.510211>
- Maietta, R. (2006). State of the art: Integrating software with qualitative analysis. In L. Curry, R. Shield, & T. Wetle (Eds.), *Improving aging and public health research: Qualitative and mixed methods* (pp. 117–139). American Public Health Association and the Gerontological Society of America.
- Maniglio, R. (2009). Severe mental illness and criminal victimization: A systematic review. *Acta Psychiatrica Scandinavica, 119*(3), 180–191. <https://doi.org/10.1111/j.1600-0447.2008.01300.x>
- Miller, C. T., & Major, B. (2000). Coping with stigma and prejudice. In T. F. Heatherton, R. E. Kleck, M. R. Hebl, & J. G. Hull (Eds.), *The social psychology of stigma* (pp. 243–272). Guilford Press.
- Oexle, N., & Corrigan, P. W. (2018). Understanding mental illness stigma toward persons with multiple stigmatized conditions: Implications of intersectionality theory. *Psychiatric Services, 69*(5), 587–589. <https://doi.org/10.1176/appi.ps.201700312>
- O'Hara, A. (2007). Housing for people with mental illness: Update of a report to the president's new freedom commission. *Psychiatric Services, 58*(7), 907–913.
- Padgett, D. K. (2016). *Qualitative methods in social work research* (Vol. 36). Sage.
- Padgett, D. K., Henwood, B., Abrams, C., & Drake, R. E. (2008). Social relationships among persons who have experienced serious mental illness, substance abuse, and homelessness: Implications for recovery. *American Journal of Orthopsychiatry, 78*(3), 333–339. <https://doi.org/10.1037/a0014155>
- Pahwa, R., Bromley, E., Brekke, B., Gabrielian, S., Braslow, J. T., & Brekke, J. S. (2014). Relationship of community integration of persons with severe mental illness and mental health service intensity. *Psychiatric Services, 65*(6), 822–825. <https://doi.org/10.1176/appi.ps.201300233>
- Pahwa, R., Fulginiti, A., Brekke, J. S., & Rice, E. (2017). Mental health disclosure decision making. *Journal of Orthopsychiatry, 87*(5), 575–584. <https://doi.org/10.1037/ort0000250>
- Pahwa, R., & Kriegel, L. (2018). Psychological community integration of individuals with serious mental illness. *Journal of Nervous & Mental Disease, 206*(6), 410–416. <https://doi.org/10.1097/NMD.0000000000000829>
- Pahwa, R., Smith, M. E., Kelly, E. L., Dougherty, R. J., Thorning, H., Brekke, J. S., & Hamilton, A. (2020). Definitions of community for individuals with serious mental illnesses: Implications for community integration and recovery. *Administration and Policy in Mental Health and Mental Health Services Research*. <https://doi.org/10.1007/s10488-020-01055-w>
- Pahwa, R., Smith, M. E., Yuan, Y., & Padgett, D. K. (2019). The ties that bind and unbound ties: Experiences of formerly homeless individuals in recovery from serious mental illness and substance use. *Qualitative Health Research, 29*, 1313–1323. <https://doi.org/10.1177/1049732318814250>
- Perese, E. F. (2007). Stigma, poverty, and victimization: Roadblocks to recovery for individuals with severe mental illness. *Journal of the American Psychiatric Nurses Association, 13*(5), 285–295. <https://doi.org/10.1177/1078390307307830>
- Phelan, J. C., Bromet, E. J., & Link, B. G. (1998). Psychiatric illness and family stigma. *Schizophrenia Bulletin, 24*(1), 115–126. <https://doi.org/10.1093/oxfordjournals.schbul.a033304>
- Rothstein, R. (2017). *The color of law: A forgotten history of how our government segregated America*. Liveright Publishing.
- Saldaña, J. (2015). *The coding manual for qualitative researchers*. Sage.
- Sandelowski, M. (2008). Theoretical saturation. *The Sage Encyclopedia of Qualitative Methods, 1*, 875–876.
- Shevlin, M., Houston, J. E., Dorahy, M. J., & Adamson, G. (2007). Cumulative traumas and psychosis: An analysis of the national comorbidity survey and the British psychiatric morbidity survey. *Schizophrenia Bulletin, 34*(1), 193–199. <https://doi.org/10.1093/schbul/sbm069>
- Smith, M. E., Pahwa, R., Harrison, J., & Sharpe, T. (in press). A social ecological model for navigating safety across time: The experience of Black adults with serious mental illnesses. *Journal of the Society for Social Work and Research*.
- Smith, M. E., Pahwa, R., & Sharpe, T. (2019, January 16–20). “A safe place to live”: The importance of neighborhood safety in community experiences for adults with serious mental illness [Conference session]. Society for Social Work and Research 2019 Annual Conference, San Francisco, CA, United States.
- Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion, 10*(4), 282–298. <https://doi.org/10.4278/0890-1171-10.4.282>
- Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances, 24*(5), 319–333. <https://doi.org/10.1192/bja.2018.29>
- Townley, G., & Kloos, B. (2011). Examining the psychological sense of community for individuals with serious mental illness residing in supported housing environments. *Community Mental Health Journal, 47*(4), 436–446. <https://doi.org/10.1007/s10597-010-9338-9>
- Townley, G., Kloos, B., & Wright, P. A. (2009). Understanding the experience of place: Expanding methods to conceptualize and measure community integration of persons with serious mental illness. *Health & Place, 15*(2), 520–531. <https://doi.org/10.1016/j.healthplace.2008.08.011>
- Townley, G., Miller, H., & Kloos, B. (2013). A little goes a long way: The impact of distal social support on community integration and recovery of individuals with psychiatric disabilities. *American Journal of Community Psychology, 52*(1–2), 84–96. <https://doi.org/10.1007/s10464-013-9578-2>
- Vijayasingham, L., Jogulu, U., & Allotey, P. (2018). Enriching the organizational context of chronic illness experience through an ethics of care perspective. *Journal of Business Ethics, 153*(1), 29–40. <https://doi.org/10.1007/s10551-016-3362-9>
- Zammit, S., Lewis, C., Dawson, S., Colley, H., McCann, H., Piekarski, A., Rockliff, H., & Bisson, J. (2018). Undetected post-traumatic stress disorder in secondary-care mental health services: Systematic review. *The British Journal of Psychiatry, 212*(1), 11–18. <https://doi.org/10.1192/bjp.2017.8>