


**ARTICLE**

# Facilitating community connections among people with mental illnesses: Perspectives from grassroots community leaders

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**Abstract**

We conducted focus groups comprising 20 grassroots community leaders to identify social and structural elements that affect community engagement among people with serious mental illnesses. Community leaders not affiliated with mental health systems have been mostly left out of the discussions about inclusion and engagement, even though they possess unique information about the places where they live and can be essential partners in making community connections. The findings from the focus groups point to elements that both facilitate and inhibit connections, as well as roles community mental health practitioners may take on, to engage with community leaders and people with mental illness to minimize barriers and foster connections in community settings. Additionally, the focus groups elucidated the interplay between the right to be a member of one's community and a community's responsibility to create a welcoming environment. The current study garnered information regarding the broader needs and implications of community connections, as well as some specific suggestions to enhance community engagement among people with serious mental illness. Hesitation and stigma around engaging individuals with mental illnesses were identified as barriers to inclusion. Further study about how community leaders and groups may be involved in facilitating meaningful community connections is recommended.

**1 | BACKGROUND**

The community mental health and recovery movements helped to invoke a paradigm shift in approaches to serious mental illnesses in recent decades, asserting that people with mental illnesses can live meaningful lives in their communities (Anthony, 1993; Davidson, 2016; Slade, 2009). This shift, which helped to reframe the serious mental illness

trajectory as rooted in recovery, rehabilitation, and health, rather than persistent and degenerative illness, is also supported by the citizenship framework. Similar to the efforts of the community mental health and recovery movements, the citizenship movement embraces both civic participation and full inclusion of people with serious mental illnesses and other "persons of difference" (Werbner & Yural-Davis, 1999) and identifies both as beneficial to both these individuals and society at large (Corrigan & Kleinlein, 2005; Janoski, 1998). Nonetheless, in spite of these efforts, individuals with serious mental illnesses continue to face significant barriers to health, social inclusion, and full citizenship (Lawless & Rowe, 2011; Miller, Ponce, & Thompson, 2011).

People with mental illnesses die 8–25 years earlier than the general population (Chesney, Goodwin, & Fazel, 2014; Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011). While access to care and stigma among medical providers can account for some health disparities (Bellamy et al., 2016; Brondani, Alan, & Donnelly, 2017), structural factors are also shown to contribute to poor health outcomes and may be accentuated among individuals with serious mental illnesses.

For example, recent work has demonstrated that social connectedness and support are positively and causally related to mental and physical health (Holt-Lunstad, Smith, & Layton, 2010; Janicki-Diverts & Cohen, 2011; Thoits, 2011) and marginalization and weak social support have been linked to all-cause mortality like that of cigarette smoking, physical inactivity, and obesity (Southwick et al., 2016). Thus, an individual's social and associational life and the health of these areas should not be considered auxiliary. This is particularly true when considering individuals who face the cascading effects of belonging to multiple stigmatized groups, such as those living with mental illnesses, substance use disorder, and having a criminal justice history, and negative effects of marginalization.

Social isolation resulting from institutionalization, incarceration, and homelessness is prevalent among individuals with mental illnesses, and the criminal justice and mental health systems often legitimize the exclusion of these individuals from the larger society (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Hartwell, 2004; Toolis & Hammack, 2015). Negative attitudes toward mental illnesses further compound this marginalization and can result in lost opportunities for employment, education, housing, and access to healthcare and other community resources (Baggett, O'Connell, Singer, & Rigotti, 2010; Holmes & River, 1998; Soffer, McDonald, & Blanck, 2010). As a result, individuals with mental illnesses disproportionately experience poverty, unemployment, homelessness, and unsafe housing and face structural and societal stigma (Chantarat & Barrett, 2012; Corrigan, Kerr, & Knudsen, 2005; Moskowitz, Vittinghoff, & Schmidt, 2013; Stuart, 2006).

Most research on social exclusion and mental health focuses on health and social inequalities at an individual level rather than focusing on structural interventions addressing the root of the exclusion (Wright & Stickley, 2013). The former favors individual, clinical interventions, which promote skill building within individuals so they can be less affected by marginalization. Although sometimes useful, individual-level interventions place the onus of responding to any systematic exclusion of people with serious mental illnesses on the very individuals who are being excluded rather than on the communities, governments, or society at large that are doing the excluding in the first place.

Community psychologists have done the hard work of elucidating the structural roots of exclusion, paving the way toward social transformation (Gokani & Walsh, 2017; Maton, Perkins, & Saegert, 2006; Munger, MacLeod, & Loomis, 2016; Prilleltensky, 2012; Prilleltensky & Nelson, 1997; Tebes, Thai, & Matlin, 2014), promoting structural change and interventions, and linking their efforts to concepts of social justice (Miller, 1999; Prilleltensky, 2012; Törnblom & Vermunt, 2007).

Based on an examination of recent research published from community psychology, it appears that the field has had a limited focus on mental health promotion and the liberating of individuals living with severe mental illnesses in the past few decades (Kloos, Nelson, & Ornelas, 2014; Martin, Lounsbury, & Davidson, 2004); however, there has been a recent call by leaders in the field to reengage with community mental health (Townley, Brown, & Sylvestre, 2018). Community psychologists have historically made notable and substantial contributions to community mental health, such as Housing First (Tsemberis, 2010) and supportive employment programs; the field's principal values, social justice, client/citizen participation, and empowerment, as well as its ecological viewpoint, situate the field in a strong position to address the structural exclusion individuals with mental illness continue to face.

One element of structural intervention involves community integration. Though often characterized through multiple objective dimensions (Bromley et al., 2013; Wong & Solomon, 2002; Wong, Sands, & Solomon, 2010), integration

into a community, like a neighborhood, is a largely subjective experience. Kloos and Townley (2011) point to perceptions of neighborhood social climate as fully mediating the relationship between neighborhood experiences and psychiatric distress. In other words, for individuals with mental illnesses, merely living in a community or occupying its physical space may not always provide a sense of stability, safety, or belonging.

Rather, as these findings suggest, psychological integration, or a psychological sense of community, is a key component of the community experience (Mair, Diez Roux, & Morenoff, 2010; Ohmer, 2007; Pahwa & Kriegel, in press; Talò, Mannarini, & Rochira, 2014; Townley & Kloos, 2011). Experiencing a sense of collective efficacy (Ohmer, 2007; Sampson, Raudenbush, & Earls, 1997) and social cohesion (Bjornstrom, Ralston, & Kuhl, 2013; Bruhn, 2009; Sampson et al., 1997) as well as having social capital (Bekkers, 2005; Lee & Brudney, 2012) can contribute to how people view the community around them and can mediate whether or not individuals get involved in civic life. In the last decade, community psychologists have aligned civic engagement with an empowerment framework, which highlights the importance of relationships in facilitating civic engagement, explicitly linking social connection and community responsibility (Christens, 2010; Fernández & Langhout, 2018; Maton, 2008).

## 1.1 | The citizenship framework

The citizenship framework is organized around “the 5 Rs”: the *rights*, *roles*, and *resources* that society offers, or fails to offer, to people through public and social institutions; the *responsibilities* that an individual assumes within the public context; and the *relationships* involving close ties, supportive social networks, and associational life in one’s community (Rowe, Kloos, Chinman, Davidson, & Cross, 2001). Citizenship exists in a dialectic, acknowledging the responsibility of the individuals to engage in their community while acknowledging that many elements of citizenship are *afforded* to individuals, and thus responsibility also lays with the community, structures, and systems that surround the individuals. This dialectic is framed clearly in recent empirical explorations of citizenship, which further revealed a sixth component of citizenship: a felt *sense of belonging* that is validated by others in one’s community (O’Connell, Clayton, & Rowe, 2017; Rowe, 2015). Belonging is not individual, but something that exists only in the context of relationships.

In thinking about social inclusion and community integration, the citizenship framework conceptually links the individual to a larger sociopolitical setting, thereby focusing on not only what the marginalized individual may need to develop or strengthen within himself or herself to participate in community, but also what responsibilities the community bears in affording opportunities for engagement in civic life. However, social inclusion and community integration promotion efforts have remained largely within the mental health system and excluded the perspectives of individuals and groups outside of the system. These community voices are rarely consulted when service providers formulate plans for community inclusion activities (Tew et al., 2012), even though community groups, such as neighborhood associations, bear some responsibility for connecting individuals to the places where they live (Alarcon de Morris & Leistner, 2009; Block, 2008; McKnight & Block, 2010).

These groups can be the source of the deepest knowledge about the social landscape and assets in their community (McKnight & Kretzmann, 2014), often from a diversity of different perspectives and experiences (Staples, 2014; Walter & Hyde, 2014), and some groups facilitate organized settings in which interpersonal relationships can be formed (Christens & Speer, 2011); thus, they can be invaluable resources for expanding a variety of connection opportunities. Service providers can also play an important role in supporting community inclusion, integration, and participation (Salzer & Baron, 2014; Slade, 2017), though that role has not been adequately actualized in most cases (Kloos, Nelson, & Ornelas, 2014). Although these individualized supports may be one part of addressing social exclusion, they are insufficient mechanisms for addressing the structural and systemic factors that contribute to, and potentially cause, mental illnesses (Atterbury & Rowe, 2017).

## 1.2 | Study overview

To extend the work on citizenship, this study sought to gather community perspectives about the barriers to and facilitators of community connections, as a way to develop further understanding on the concepts of relationships and

belongingness for people with mental illnesses. We held focus groups in New Haven, Connecticut, over a 2-year period. The research team sought to understand which elements were most important to making connections in the community, as identified by residents who are involved in their community. The perspectives of community leaders can add to the existing data generated by research with people with mental illnesses, care providers, and family members. More specifically, this study sought to answer from the perspective of community leaders, "How are community connections made? What strategies are employed to facilitate community involvement and encourage individual participation? How do these strategies apply or not apply to those with mental illnesses?"

## 2 | METHOD

This study was part of a community collaborative that comprised people with mental illnesses, researchers from Yale University, community organizers, and service providers in the community mental health system, including peers. The community collaborative is organized around improving citizenship for individuals with criminal justice histories and mental illnesses. This study was conducted with the goal of informing the next phase of the community collaborative's work.

### 2.1 | Participants

Community members (14 women and 6 men) were recruited by two members of the research team, who are both trained community organizers. They drew from a convenience sampling of community leaders with whom they either had worked or knew through other networks. Maximum variation sampling (Patton, 2002) was also used to ensure diversity across race, ethnicity, age, gender, sexual orientation, and religious affiliation. Diversity of roles in the community was emphasized to represent a cross-section of various stakeholder groups that are involved in building and shaping the particular community studied. None of the participants had previously been affiliated with the work of the community collaborative. Approximately 25 people were contacted via email, phone, or in person as potential participants and 20 agreed to participate.

The first focus group comprised four participants, two women and two men, and included a journalist, a community activist, a retired social worker and community activist, and an Episcopalian priest. Three of the participants were White and one was Latina.

The second focus group comprised six participants, five women and one man, and included a Christian minister, a community organizer, two leaders from a local masjid, a refugee resettlement worker, and a political campaign consultant. Five of the participants were African American and one was White.

The third focus group comprised four participants, three women and one man, and included two child and family services workers, a labor organizer, and a graduate student. Two of the participants were African American, one was South Asian, and one was White.

The fourth focus group comprised six participants, four women and two men, and included two community organizers, an antihunger activist, two public school teachers, and a visual artist. Four of the participants were African American and two were White.

The ages across the groups ranged from early 20s to early 70s. The age ranges were as follows: One participant was in the 20–29 range; three participants were in the 30–39 range; four participants were in the 40–49 range; eight participants were in the 50–59 range; three participants were in the 60–69 range; and one was in the 70–79 range. Focus group leaders did not collect socioeconomic data from participants. We received approval for this study from our university's institutional review board.

### 2.2 | Procedures

The best method of data collection when trying to gather information on a little-known topic in which there may be a vast difference in experiences is focus groups (Stewart & Shamdasani, 2015). Focus groups allow for participation

by more people than individual interviews and allow for an exchange of information and ideas between participants. A semistructured interview script was developed by the community collaborative and included questions on how to encourage individuals to participate in community groups, the elements of a good community group, and how to sustain involvement.

We held four focus groups. The first two were led by the initial project manager (AC) and the director of a citizenship intervention (PB) or a research assistant. The third and fourth groups were facilitated by the second project manager (LK), the citizenship intervention director (PB), and one of the community organizers (BB). Facilitators provided information and obtained informed consent individually from each participant. They also went over ground rules collectively, which included no use of names and an understanding that the content of the focus group was confidential. All focus groups were audio recorded. Participants received \$10 cash as well as food and drinks as compensation for their participation.

## 2.3 | Data analysis

Focus group recordings were transcribed verbatim. Inductive thematic analysis (Braun & Clarke, 2006) guided the analysis because the goal was to stick as close to the data to generate descriptive themes regarding community connections. The first and second authors (BB and SB) employed line-by-line coding of two transcripts. These coded transcripts were merged and the two coders reviewed codes for areas of agreement and disagreement in coding. Once the discrepancies were addressed through consensus, a codebook was created. These initial codes were presented to the rest of the team for clarification and input. With a revised codebook, BB and SB coded the final two transcripts and recoded the first two transcripts independently.

BB and SB met to discuss codes as well as possible themes and structures present in the data, which were organized into the following categories: accessibility, barriers to connecting, common interests, dynamics/sustainability, information, personal invitation, stigma, and support. These categories, a summary statement of their definitions, and representative quotations were distributed to the rest of the team. The team met to review and discuss the categories and their meanings and connections and reached a unanimous consensus of all themes. The findings were conceptualized and organized around interpersonal and structural components of facilitators and barriers to good community connections.

## 3 | RESULTS

### 3.1 | What makes for a good connection?

Participants in the focus group identified a number of elements that contributed to facilitating a good connection to a community, including community ethos, valued roles, personal invitation, and information. In many ways, for the participants, these subthemes each amounted to creating a welcoming community.

#### 3.1.1 | Community ethos

One theme that emerged from three of the four focus groups was the idea that the atmosphere that a community maintained—the community ethos—was an important element for others wanting to get involved with that community. This was based on the concept that communities create environments reflecting a shared ethos. The majority of the comments about community ethos focused on small- to medium-sized group settings rather than neighborhood or larger community settings. When talking about the atmosphere, many of the comments were idealistic in nature, often describing a setting featuring support for individuals who join the community, as exemplified by this participant's invitation:

*But come on in whatever your problems are. We'll accept you. We'll love you. We'll treat you like a person. We'll use you for what we can get out of you and give you what we have to give. (Male participant, Christian minister)*

Other comments related to the atmosphere introduced more practicality, and proposed motives, for getting involved in the community. One motive cited was a feeling of empowering “energy” from the community, which gives the individual a reason to return after the initial encounter:

*That's what keeps people involved in anything, whether we're talking about movements, going to church, or whatever is that feeling of energy and community, and if you go to something and it feels bad, you don't want to go back. You keep going because it was empowering or it was challenging in some way that was good or there was community. (Female participant, child and family services worker)*

### 3.1.2 | Valued roles

According to participants, the existence of a certain ethos and atmosphere was related to the individual having a valued role within the community group setting. As noted by this participant, a critical element of community participation was the idea that an individual is needed within a community, and that their contribution affects the community in a genuine and significant way,

*Another thing that's really important is people feeling like their presence will be important or like them being there matters in some way. So, it's not just like, oh, is this interesting to you, but it's meaningful that you're there and for whatever form that takes. Like you're contributing something. We need you to bring the salad. Even just giving someone a task can be important but in an organizational setting, like you can contribute something to this larger thing. (Female participant, graduate student)*

Other participants extended the significance of valued roles to include people with disabilities. One participant connected the concept of an intentionally welcoming community, cited in the Community Ethos subsection, with the centrality of valued roles in making community connections,

*And the idea is that, within a community, there's—no matter how disabled someone is by what's going on with them—there's something that they can contribute to that community. And if, you know, like if what you do is water the plants but somebody else can help prepare the meal or plan the meal, or every single person within the community has something that they can do that they can contribute. (Female participant, retired social worker and community activist)*

The establishment of a personal connection to the individual joining the group was also cited as a mechanism for someone gaining a valued role in that group,

*For me, it's like people feel [like it's not] another chore or I'm just a body, but that whole personalism, you know. You name it. You say, “Come do this with us,” you know, “We need you.” (Female participant, community activist)*

### 3.1.3 | Personal invitation

Many participants stressed the importance of personal invitation in establishing the personal connection that can be so important to community groups. Having someone personally extend an invitation to participate in a group or community activity was cited as critical to drawing people in, as noted by a participant:

*Much more so, I mean, not that people won't respond to a flyer or a Facebook post, or a poster, but when you say to someone, “Would you come?” and give them a specific time, make it a real invitation, “Would you come Sunday afternoon? We'd love to have you at the house of worship, at my backyard, at meetings at the farmer's market to say hello,” or whatever. (Male participant, journalist)*

Participants indicated that personal invitations could help target specific people community members know who have specific interests or talents that can benefit the community. Another benefit of personal invitations was that it ensured the inclusion of people who are often overlooked or outcasted,

*And so, if there are things that we were doing to make sure that people were included and recognized for their gifts and their talents that they contribute to the community and not always looked down upon... Things that*

*bring people in, that bring people together and make them feel like they're part of the community. So, I think that's one of the successes I've seen in bringing people in that you know were normally outsiders. Invite them in.* (Male participant, Christian minister)

This personal invitation not only facilitated a sense of connectedness and belonging before someone even participated in the community, but it also allowed community members to provide more information than could be conveyed in a flyer or on social media. This was especially beneficial if the person extending the invitation was perceived as a credible source, like a friend or a respected community leader:

*So, it's getting the information out but getting that personal information, getting someone to give it to them personally. So somebody they know or they already have a connection with because someone, again like their church or the store that they go to, if somebody they know is talking about it or is saying they're going to go to it, they might also be more drawn to go out to something.* (Female participant, child and family services worker)

### 3.1.4 | Information

Several participants cited availability of information as an important mediating factor in connecting to the community. As already noted, the use of personal invitations provided an opportunity to share more information. Participants also noted they were more effective when accompanied by information about the community resources or activity. That said, information sharing did not need to be connected to a personal invitation to be effective. Participants noted that sharing information about a community event can foster a connection, as this participant explained:

*And having helpful people who tell you about something makes all the difference in the world too. I mean, I know someone ... people said to me, "Oh, did you know that such and such?" "No I didn't know that." You know, and then that opened a door for me to something. So, I suppose if you're connected with people or you talk to people that you know someone could really open up a world for you by just telling you something that you didn't know.* (Female participant, antihunger activist)

Just as invitations when personalized held greater weight, some participants suggested that information is more effective when someone shares it in person, as noted here:

*I mean, that's the way to get the information out. I'll listen to her way more than ... I won't read that piece of paper. I haven't checked my mail in over a month. So you put it in the mailbox, I'm not going to see it.* (Male participant, Christian minister)

Participants talked about the reciprocal nature of information. They noted that it required both community responsibility to "spread the word" about their activities and individual responsibility to seek it out.

*There are a lot of things already happening, right? So, you don't have to reinvent the wheel. It's just getting education to all those groups and to all those places where people are already gathering.* (Female participant, political campaign consultant)

## 3.2 | What impedes connection

Participants emphasized that while making a good connection was a feasible goal comprising a number of elements, there were certain ideas and activities that hampered that goal. Namely, the group identified accessibility, information, and stigma. Notably, information functioned as both a facilitator and an impediment, according to the group. Ultimately, as noted below, its influence on the process was contingent on how it was used.

### 3.2.1 | Accessibility

There were several barriers cited by participants, which point to challenges with accessibility. Structural factors were commonly cited as reasons why people do not connect to their community. Primary among the structural barriers cited was a lack of available or convenient transportation options.



*A lot of times transportation is an issue. Like, you can know about organizations and you can know about where they are within your vicinity and, like, you know they're there. But it's actually physically getting there. (Female participant, public school teacher)*

Participants cited language barriers as inhibiting connections. One participant suggested that community groups can adapt to that barrier by acknowledging an individual's culture but admitted that it was not fully addressing the problem of not being able to communicate effectively with prospective members:

*I was just thinking about that because language is a problem, and it's not that when you start thinking you don't want to say okay we're going to have something for everyone's language, but it's about respecting the culture that someone is kind of bringing to you. (Female participant, visual artist)*

The effects of financial constraints were also discussed as barriers to making community connections. Several participants referred to what the effect of struggling "to make ends meet" had on people carving out free time to join in community activities,

*If you're working two jobs and trying to make ends meet and doing all this other stuff ... it's not likely that you're probably going to spend your free time going to a community meeting or doing some other thing. (Female participant, child and family services worker)*

### 3.2.2 | Information

Although having information about community resources and events was cited as an ingredient for fostering community connection, it was more often cited as a barrier to connection. Several participants gave examples of times when they, or someone they know, would have liked to participate in something but did not find out about it until it had already happened. Participants shared that the basic information about community events was not disseminated well in most areas of the city, "One, just not having the knowledge of the resources. If they don't know about it, they won't reach out or even try." (Female participant, child and family services worker) and, "Information. You can't make a connection if you don't know how, where, when, and information is just not out there." (Female participant, child and family services worker)

One participant noted that a lack of available information about community opportunities conspires with other structural barriers to make connections feel out of reach:

*The main thing is they don't know. They don't know their rights. They don't know where services are and sometimes they just don't have the energy to go out and find out all those things. (Female participant, child and family services worker)*

### 3.2.3 | Stigma

Stigma was another structural barrier that impeded community connections, specifically for people with mental illnesses. In some of the focus groups, people with psychiatric and intellectual disabilities were characterized as possibly presenting as "scary" or having the potential to be violent. Other participants felt that in community environments there should be a person responsible for "managing" those with mental illnesses so other participants are shielded from having to feel uncomfortable or deal with "challenging" behaviors. One participant made the contrast in accommodations for people physical disabilities to potential accommodations for those with psychiatric disabilities,

*It's kind of easier to get your head around [accommodating persons with physical disabilities]. You can build a ramp, you can do whatever, these kind of pragmatic ways. Mental health, it's exhausting to kind of get your head around. You can't really, in my experience, you can't really fix it. It's ... not a quick fix type of thing, and that makes it very difficult. (Male participant, Episcopalian priest)*

Because accommodating mental illness is not seen as being addressed as easily as physical disabilities, many questioned their personal ability or an organization's ability to accommodate people with mental illnesses at community events. This also showed that accommodations for people with physical disabilities have been integrated into our



society; when faced with the dilemma, people know how to respond, at least in granting accessibility. However, accessibility does not guarantee acceptability, as a few people expressed concern that the presence of people with mental illnesses in community organizations may make others feel uncomfortable:

*Once in a while I bump up against someone I'm not, it's often because they're mentally challenged in ways I've never experienced before. It's just not fair to say, "Well, he has his needs, they have their needs."... If you work with people who are mentally disturbed, as you do, you know it's that they throw a wrench into the works of people who deal with them. (Male participant, journalist)*

Other participants acknowledged the presence of stigma, which was attributed to the media's portrayal of people with mental illnesses as being potentially violent. However, labeling within communities also occurred:

*If there's a center in our community, sometimes it can be labeled that's where all the crazy people go, or that's where you go for a specific issue for whatever and some people just don't want to be seen going into that particular building, and especially if that building is not reflective of their own community. (Female participant, child and family services worker)*

This acknowledgement that certain places are labeled and individuals associated with it may be also labeled, and in turn stigmatized, also implicitly raises a concern about other community spaces being labeled as such should those with mental illnesses start participating there.

Even when an organization has created a space for and welcomed individuals with mental illnesses into their community, individuals within that community may continue to hold negative views toward individuals with mental illnesses and experience their presence as an inconvenience or even an intrusion. One participant spoke of his friend whose religious community has welcomed individuals with disabilities into their congregation, yet the individual is not "on board" with this endeavor:

*The expectation is placed on [the congregation member] at a time when he does not feel ready to bear that, to shoulder that expectation.... His community expects him to interact with patience and forbearance with some adults who have needs, who can be very difficult. (Male participant, journalist)*

This individual spoke of how the larger organizational community had "come together" to support and welcome individuals with mental disabilities into their community but felt that in doing so this ignored the "needs" of the nondisabled community members who did not wish to be inconvenienced or burdened by having to "manage them." He felt it was the organization's responsibility to have a designated person "who made sure that it wasn't his job, my friend's job, to manage them, if [the individuals with mental disabilities] weren't just set loose."

## 4 | DISCUSSION

We set out to understand what community leaders may uniquely add to the rich conversation about inclusion, integration, and citizenship based on the principle that all stakeholders should have a voice in conversations that affect them. Like other voices that have contributed to the current theoretical base of citizenship and community involvement, people with mental illnesses, peer workers, other service providers, academics (Ponce, Clayton, Gambino, & Rowe, 2016; Ponce, Clayton, Noia, Rowe, & O'Connell, 2012; Rowe et al., 2001), and community leaders can add perspectives accrued from their unique experiences with their own citizenship and community involvement, enhancing the knowledge base. In that way, the focus groups sought to include expertise that may otherwise remain unavailable.

During focus groups, we found that structural barriers related primarily to poverty (e.g., lacking access reliable information, inadequate transportation, reduced access to safe and enriching public spaces) impeded community connections. This finding showed how the structural force of poverty can get reproduced in surprising and unintended ways because the people who could benefit the most from community connections have the most difficulty accessing them.

The focus groups also produced information about elements that foster connections and may mitigate some of the circumstances and conditions that inhibit connections. Most of these required community members to actively take

on the role of bridge builders and offered remedies to the deleterious effects that abdication of that role can cause. Sharing information about events in person, ideally accompanied by a personal invitation, was consistently cited as a way that community leaders can engage people who are marginalized in the life of the community.

Finding valued roles for people who show up for an activity or a community meeting was also consistently cited as an essential element. When a personal welcome is accompanied by valued roles for new members in the group, a supporting and even empowering community ethos can be created. These elements, as identified by focus group participants, provide material for a road map that community leaders and groups may follow to engage and support people who have been marginalized within and by their communities. In the following section, we propose that along with the role community leaders must play, behavioral health and other practitioners must actively seek out and enhance the effect of community leaders who are fostering community connectedness.

A surprising but not entirely atypical finding was the level of stigma present in the focus groups; conversations additionally demonstrated persistent stigma among the community members who often facilitate these connections. Individuals with mental illnesses were referred to as difficult and potentially violent. These perceptions of mental illnesses were interestingly distinguished from otherwise comparable physical disabilities in that physical disabilities lent themselves to quick fixes like building ramps, but there was no clear means for accommodating the needs of a person with a mental illness. This supports an existing trend in mental health literature showing that stigmatizing behavior pervades even the dialogue of those who work most closely with people with mental illnesses (Schulze, 2007).

Stigmatizing behavior among mental health professionals can often be couched in a tendency to protect clients from risk (Bromage, Kriegel, Williamson, Maclean, & Rowe, 2017; Rowe, 2015). During focus groups, participants seemed to mirror this tendency by suggesting the superimposition of mental health interventions on community connections, including the accompaniment of a provider for a person with a mental illness engaging in nonmental health activities. This type of suggestion carries with it the following assumptions: (a) a person with a mental illness doesn't have the right to be in the community as a sovereign, independent citizen unaccompanied by a worker, and (b) the community itself doesn't bear a fundamental responsibility for welcoming and accommodating people who want to join them.

Interestingly, this finding brings to bear a fundamental obstacle for community connections. Even among those who identify as connectors and organizers, inclusion of people with mental illnesses is limited. In identifying ways to connect, participants also identified ways in which they disconnect or isolate certain individuals who do not align with a community norm. We propose that this abdication by communities to take the necessary steps to welcome people they perceive as different on their own terms, without an intermediary such as a provider, is a primary barrier for community connection. We also acknowledge that the lack of a welcoming environment among communities may also result from a combination of stigma and behavioral health practitioners abandoning their role as bridge builders or "community guides" (McKnight, 1995) in the communities where their clients live.

#### 4.1 | Implications for practice

In order for community groups to develop the welcoming atmosphere cited by several participants as integral to community connections (see the Community Ethos section), communities require support as they shift from being made weary by *accommodating* people who are perceived as different to having the capacity to *welcoming* and *engaging* them to, finally, *benefitting* from their contributions. The findings elucidate the participants' insights on some of the mechanisms of community connection in general and insights specific to people with mental illnesses or other factors that cause them to be perceived as different. There is a role for mental health practitioners to play in partnering with community leaders and community organizers to build these findings into specific practices that may positively affect people with mental illnesses. Some potential dimensions of that role follow.

Rowe and Davidson (2016) suggest that mental health professionals may consider a "two-path" approach, focusing on both the individual client and the "community change." They propose going outside of the traditional mental health milieu to work with community groups to prepare them to welcome people with mental illnesses who may want to join them. The authors suggest that this approach has significant potential for moving the current lack of community connection, by deliberately building bridges between those who want to make a connection and those who offer a way

to connect. This “two-path” approach ties into the notion that practitioners bear a responsibility to work alongside community partners to enhance recovery and citizenship (Rowe & Davidson, 2016).

Examples of programs that support linkages between people with mental illnesses and people and organizations in their communities already exist in behavioral healthcare settings. These include an extensive citizenship curriculum taught in a classroom setting, support for individuals exploring their passions and interests in community settings, and community building with neighborhood groups (Bromage et al., 2017; Rowe & Davidson, 2016; Rowe et al., 2007).

The larger framework of citizenship, from which the aforementioned community connection interventions emanate, may also advance the effect of connections between communities, behavioral health practitioners, and people with mental illnesses. The concept of citizenship has been useful in understanding the individual skills and resources necessary to achieve one's place in the community (Clayton, O'Connell, Bellamy, Benedict, & Rowe, 2013; Rowe et al., 2007), but it also explicitly acknowledges the roles and responsibilities that communities bear in addressing the structural and interpersonal discriminatory factors that perpetuate the marginalization of individuals with mental illnesses (Rowe & Pelletier, 2012).

Additional dialogue between community leaders and mental health professionals incorporating citizenship into their practice may address the lack of information and opportunities to make connections, which were cited in the focus groups. Both groups have a significant store of knowledge that can benefit the other. Dialogue can be initiated by mental health professionals, as they assume responsibility for addressing the structural factors that affect their clients' mental and physical health (Bromage et al., 2018; Manseau, 2015; Metzl & Hansen, 2014; Shim & Satcher, 2015), including factors like transportation issues, lack of financial resources, stigma, and other topics identified during the focus groups.

Seeking out community leaders, who are actively taking on these issues in the neighborhoods where people with mental illnesses predominantly live, and activists and local government leaders, who are taking on other structural issues in the municipalities in which mental health service providers operate, is an essential first step to assessing available resources and forming relationships (Rowe et al., 2001).

Practitioners may in turn share knowledge about mental illnesses and recovery and provide suggestions about how community leaders can be allies, thereby expanding the amount and quality of information in neighborhoods about some of the gifts and talents that people with mental illnesses may contribute and challenging the stigma that can inhibit recognition of those potential contributions. This would certainly be enhanced by the participation and leadership of people in recovery from mental illnesses, including peer workers. This type of approach allows for practitioners to help moderate the community connection process without fully participating in a way that would disrupt the natural connections people with mental illnesses make in community settings that are not oriented toward the mental health identity.

The focus group data clearly indicated that structural factors pose significant barriers to community connections for many people living in poverty, including many people experiencing mental illnesses. The recent re-connection of community psychology to community mental health is timely, as implied in these findings; there is a need for behavioral health practitioners to understand structural barriers in a more comprehensive way before they can effectively develop concrete strategies to address the effects of structural barriers on the social lives of people with mental illnesses. Community psychologists are well-positioned to move this work forward, bringing their expertise related to coalition building, measurement, and research, to assess, elucidate, and pose creative solutions to address the barriers social structures pose to the integration and liberation of those living with severe mental illnesses.

Metzl and Hansen (2014) advocate for *structural competency* as an educational tool to increase awareness about barriers in accessing the social and financial resources people need to thrive. Implicit in this education is a call to action, urging practitioners to “attend to the social structures that shape and enable stigma's underlying assumptions” (Metzl & Hansen, 2014, p. 131).

Structural competency educational activities have been incorporated into medical school curricula in several U.S. universities. Some of the activities are as follows: integrating readings and films that examine racism into classroom sessions (Wear, Zarconi, Aultman, Chyatte, & Kumagai); service-learning opportunities to work with underserved populations (Metzl, Petty, & Olowojoba, 2017); mentorship in clinical and community settings provided by peer support

workers (Hansen, Braslow, & Rohrbaugh, 2017) or in partnership with community health workers (Wear, Zarconi, Aultman, Chyatte, & Kumagai, 2017); integrating legal services into clinical settings alongside medical residents to highlight structural barriers faced by patients and to offer practical resources (Paul, Curran, & Tobin Tyler, 2016); and participating in a series of sessions led by community leaders and peer support workers including walking tours in low-income neighborhoods adjacent to the university (Bromage et al., 2018).

Underlying all of these approaches is a focus on revealing unconscious biases and illuminating racial disparities in ways that are genuine, rather than superficial or tokenistic, along with developing “structural humility” to value the lived experience of structural barriers to health among patients (Metzl & Hansen, 2014). The authors contend that expanding the structural competency approach into other fields, and thus sensitizing providers to the forces that foster stigma and marginalize individuals and communities, could potentially have far-reaching implications for more successfully supporting people with mental illnesses who are seeking community connections.

## 4.2 | Directions for future research

Future research may more explicitly address the specific needs of community to support connections for people with mental illnesses. Although the current study garnered invaluable information regarding the broader needs and implications of community connections, the expressed hesitation around engaging individuals with mental illnesses implies that even at our most inclusive we still continue to resist certain vulnerable groups. This resistance demonstrates a lacking regard for basic human agency—valuing the needs and agency of more privileged individuals over those who present an “inconvenience.”

Likewise, instead of focusing solely on the needs of individuals seeking connections, future research may focus on the ways in which individuals and groups committed to community building struggle to offer citizenship and inclusion opportunities to people in their community. Future research may also focus on which community members and groups may best facilitate meaningful community connections for this marginalized population and the effect of sense of community-responsibility (Nowell & Boyd, 2014) among community leaders on creating welcoming spaces which support inclusion.

## 4.3 | Conclusion

This study draws from a diverse stakeholder group yielding a variety of insights, but specific aspects of each group that may promote or inhibit community connection were not examined. Personal experiences with mental illness, in participants' own lives or in the lives of their family members and how those experiences may affect community connection, were not examined either. Mental health practitioners need to (a) be educated by community groups about what they have to offer and (b) understand what the groups may need from practitioners to provide a more welcoming environment. This requires a more intentional relationship with community partners than has traditionally been pursued. Having information about how that may work best directly from community leaders may enhance that process.

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