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BRIEF REPORT

Social Perceptions About Community Life with People with Mental Illness: Study of a Discharge Program in Buenos Aires Province, Argentina

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Abstract Effects of living near people with mental illness in community settings have been researched as part of psychiatric reform evaluation. However, these studies have been carried out mostly in industrialized countries, where social contexts differ from those in which psychiatric reform is now being implemented. To analyze the effects of community life with people with mental illness in the neighborhoods in which they live, in Buenos Aires, Argentina. A questionnaire was administered to randomly-selected neighbors of group homes of a discharge program and an equivalent control area (n = 236). Data was analyzed both quantitatively and qualitatively. Significant differences were found between being a neighbor and having a high degree of acceptance toward people with mental illness. In addition, significant associations were found between neighbors having a high-perceived social cohesion and having a high level of acceptance toward the mentally ill. Living near people with mental illness is associated with better acceptance toward them; these results are congruent with those results found in other cultural contexts.

Keywords Community integration · Mentally ill persons · Social perception · Community mental health services

Introduction

Psychiatric reform was developed around the world during the last 60 years, one of its main features being the movement of care from hospital settings to community-based ones. Specifically in Latin America, psychiatric reform has a long and complex history. Its beginnings date to the 1960s, following the reform movements in European countries, community psychiatry from the United States,

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and World Health Organization guidelines (Caldas de Almeida 2005). Despite the energy of this early movement, its momentum was delayed or interrupted due in part to two phenomena in the region: military dictatorships and health care systems reforms.

The first one—military dictatorships—took place in many Latin American countries during the 1970s and 1980s. In that period discontinuation of community experiences was ordered because military governments considered meetings or group activities to be suspicious and dangerous. Also, due to their social labor, mental health workers were a target of these governments. In Argentina, for instance, during the last dictatorship (1976–1983) 110 mental health workers and 66 students of related careers were *disappeared* and many others were exiled (Carpintero and Vainer 2005).

The second—health care systems reforms—occurred during the 1990s and were based on the managed care model (Iriart et al. 2001). In the context of the state reform proposed by the Washington Consensus (Almeida 2001), health care systems were reorganized and mental health care facilities became especially vulnerable. In Colombia, which has one of the best models of managed care in the region, the advances on psychiatric reform were interrupted and many facilities were closed because they were not considered profitable enough (Ardila-Gómez 2009). Other aspects that were an obstacle to the reform should be considered, such as competition between and within different professional sectors, and the reluctance of some hospital unions to introduce changes in their institutions.

Given this context, mental health care provision today in Latin America varies widely and only in some countries does psychiatric reform constitute the predominant approach. Even though there is a general acceptance of psychiatric reform ethical principles, and many countries have progressive mental health laws and policies (Bolis 2001, 2002), there is still a gap between these normative frameworks and actual care provision (Ardila-Gómez 2008; Barrientos 2002; González Uzcátegui 1992).

Nevertheless, there have been different experiences of community-based care around the region, but they have had limited dissemination and there are still few studies and analyses of them from a scientific perspective. Based on the assumption that the fostering of scientific evidence in favor of psychiatric reform experiences is crucial for their strength, both technically and theoretically, and furthermore for the improvement of the quality of life of people with mental illness (Thornicroft and Tansella 2002) and the respect of their human rights, a research program was developed. This program, based at the National University of Lanús and started in 2008, evaluates community-based services and programs in Argentina. One of the main questions of this program has been to determine the effect of living nearby people who have been discharged from psychiatric hospitals.

Specifically, a key component of the community-based services is housing, due to the fact that during the process of becoming psychiatric patients, people lose the social support that allows them to live in the community. The right to live in the same environments as the rest of society is part of the protection and fulfillment of the human rights of people with mental illness (Saraceno 2003; United Nations 1991).

There are different studies regarding housing as part of the deinstitutionalization process, which have explored the attitudes of communities toward the inclusion of mental health housing facilities in their neighborhoods. Their results have shown that neighbors' negative attitudes toward mental health housing facilities are not as frequent as expected (Antos Arens 1993; Taylor and Dear 1981; Unger and Wandersman 1985). Nevertheless, common sense knowledge still supports the assumption of neighbors' resistance. The results have also revealed that a high proportion of neighbors do not know about the presence of the facilities (Rabkin et al. 1984; Unger and Wandersman 1985) and that the expectancy of negative effects in the neighborhood due to the establishment of a facility is more frequent in areas in which there is not a facility than in those in which there is one (Cook 1997). Also, it has been proposed that in neighborhoods with a low social cohesion, integration of facilities' tenants is more common than in those with high social cohesion (Segal and Aviram 1978; Taylor et al. 1979). Finally, a few studies have explored the positive effects of housing facilities in the neighborhoods, finding that neighbors report being more tolerant toward people with mental illness, to have learned about people with disabilities and to have more positive attitudes regarding the facilities (Antos Arens 1993; Cook 1997).

The studies cited above represent important advances for the building evidence regarding mental health housing facilities and more broadly about deinstitutionalization. Nevertheless, all of these studies have been carried out in the northern hemisphere in the years directly following the psychiatric reform in those countries; moreover, health conditions and social and cultural contexts were likely different from those in which the reform is currently taking place in the southern hemisphere, and more specifically, in Latin American countries. Based on that, a study researching neighbors' perceptions of community life with people with mental illness was carried out in Buenos Aires, Argentina, exploring the effects of community life with people discharged from psychiatric hospitals, emphasizing the positive effects on the neighborhoods. Although it has been explored in previous studies, more evidence on this topic was necessary from a public health and social policy perspective to further evaluate the effects of a facility on populations indirectly affected by the programs.

Two hypotheses were explored in this study. First, that community life with people with mental illness correlates with fewer prejudices toward this population. Second, that given the social and cultural features of Latin American countries, the relationship between social cohesion and attitudes regarding people with mental illness would be different than the reported in previous studies, which means that higher social cohesion correlates with acceptance of people with mental illness.

Methods

The study was conducted in the Buenos Aires Metropolitan Area (locally known as Greater Buenos Aires) which is home to almost one-third of the Argentine population, or about 13.5 million people (INDEC 2010). Located in the southern zone of Greater Buenos Aires is a psychiatric hospital for women, Hospital José A. Estéves, which has one of the longest histories in that region of developing psychiatric care reform as proposed by the World Health Organization (PAHO/WHO 1990). It consists of a rehabilitation program which provides services to support the discharge of individuals with mental illness who have no social or family support. Discharged patients are aided with the provision of housing, continuity of care and various supportive daily activities. Work with the participants in the program begins by teaching them the everyday life skills needed to live outside the hospital, such as shopping and use of public transport. After that, they move to state-supported group homes. The program also has a community center available to the entire neighborhood, offering cultural and educational activities. The program has been functioning since 1999, and although it was designed to be implemented in every psychiatric hospital of the Buenos Aires Province, it remains following the original guidelines only in this particular hospital (Cáceres et al. 2009).

Participants

Eleven of the 12 group homes managed by the program at the moment of the study (2012) were chosen for the definition of the study areas. The group homes were located in five different districts of southern Greater Buenos Aires, in middle class neighborhoods which in the last century have developed due to new nearby train stations. They are still primarily residential areas. The group home that was excluded from the sample is located in the downtown of one of the districts, which is predominantly a commercial area with mostly non-residential buildings. The group homes are small, between two and five tenants, women in all cases, and mostly in their fifties and sixties. The majority of the homes have been established in the neighborhoods for at least 10 years and only one has been recently added, in the year previous to the study.

Based on the 11 group homes, six areas were mapped. One of these areas included six homes because of their proximity and five had only one group home each. They were labeled as *high density* and *low density* areas, respectively, for analysis purposes. Each study area featured the group home or homes in the center and included two blocks in all directions from each group home. Control-group (not neighbors' areas) areas were defined as those of equivalent size and social characteristics, located at least four blocks away from the nearest group home. Each low-density area was composed of 16 square blocks and the high-density area was composed of 24 square blocks.

Once mapped, four blocks in the low-density areas and six in the high-density area were randomly selected, and the same was done for the respective control areas, to establish the sites for administering the questionnaire. The sample was 240 people who answered the questionnaire: 120 in the study group and an equivalent number for the control. All were adults (men = 113, women = 123); aged 19–92 years (mean = 51, SD = 17.098) with a mean educational level of having high school diploma (12 schooling years).

Instruments

A questionnaire was constructed with 35 questions and divided into four areas: (a) Socio-demographic data (10 questions); (b) Neighborhood features (11 questions, such as: *Has this neighborhood changed in the last 10 years? In this neighborhood people know each other: a lot, somewhat, a little, not at all?*); (c) Attitudes toward specific groups (five questions, such as: *Score from 1 to 10, with 1 being the lowest and 10 the highest, the degree of neighborhood acceptance toward people with the following features: physical disability, mental retardation, mental illness, alcohol or drug consumption*); and (d) Attitudes toward mentally ill persons, their treatment and community integration (seven questions, such as: *What do you think about people with mental illness? What do you think the treatment of people with mental illness should be?).* Two additional questions asked for other comments of the respondent and if he/she gave permission for being contacted again for a more in-depth interview.

The questionnaire had both open and multiple-choice questions. It was administered in the homes of the respondents and took about 15 min. It was administered by research assistants who were advanced undergraduate students of social work and psychology and who had been specifically trained for the study by the research team.

Procedures

Research assistants administering the questionnaires were given the instruction to complete an established number of questionnaires, following an established order of randomized blocks in each area. They were to knock on doors until they spoke with the assigned number of respondents, following a pre-defined route. The overall response rate was 28.8 % (29.5 % for the study group; 28.2 % for the control group). The research assistants did not know if their assigned area was a study or a control one. The questionnaires were all administered on a saturday, based on the assumption that it would be easier to contact the residents that day. The instruction was to administer the questionnaire to the first adult to come to the door. Before administering the questionnaire, the pollster identified him or herself as student of the university responsible for the study, presented the objectives of the study and gave the person the contact information of the principal researcher. The pollster explained to the respondent that answering the questionnaire was voluntary, that it would end when the respondent decided to, and the approximate time it took to answer.

The study had been approved by the Institutional Review Board of the National University of Lanús.

Data Analysis

SPSS 18.0 was used for the quantitative analysis. Qualitative analysis of the open questions was performed by triangulating the analyses of each of the research team members (Coffey and Atkinson 1996). In order to assure agreement in labeling questions, each member categorized the questions, discussed the categories with the team in order to define a common matrix, and reread the questions based on the established categories.

Included for the analysis were 236 questionnaires, excluding four due to missing data. After reviewing total sample frequencies for each item comparisons were made between the study and control subsamples for all the questions. Additional analyses emphasizing the study subsample were made according to socio-demographic variables, perceived neighborhood social cohesion, density of group houses in the specific area, time of the group house in the neighborhood and distance to the group house.

Results

Socio-demographic Data

The study and control groups were equivalent in all socio-demographic variables measured. Of the sample, 47.9 % were men and 52.1 % women, which values for general population are 48.25 % men and 51.75 % women. In terms of age, 4.7 % were young adults (19–24 years old), 72 % were middle-aged adults (25–64 years old) and 23.3 % were older adults (65 or more years old), and the values for general population (adults) are 14.43 % of young adults, 69.66 % of middle-aged adults and 15.84 % of older adults. About schooling, seventy-one percent had a level equal to or higher than high school diploma, being the percentage for the general population of 37 %. Regarding employment, 64.8 % were employed (68.73 % for general population), 15.7 % were homemakers and 15.7 % were retirees. Of the sample, 58.5 % were married or lived with their partner (64.73 % for general population). It is important to note that the available data for general population corresponds in the case of sex and age to the municipalities where the sample was taken, for schooling to the Greater Buenos Aires area, and for occupation and marital status to the Province of Buenos Aires. The difference in schooling between the sample and general population is possibly due to the fact that the sample corresponds to middle class neighborhoods.

In terms of length of time living or working in the neighborhood, 75.2 % had spent a significant amount of time there, with 11.9 % having lived there between five and 10 years, and 63.3 % more than 5 years. It is important to emphasize that 67.5 % of the study group had lived in the neighborhood since before the establishment of the housing program.

Neighborhood Features

Of the respondents who had lived in the neighborhood for 10 or more years, 62.8 % considered that it had changed during that time. The changes noticed were related predominantly to infrastructure and decreased security, and 23.4 % reported changes related to *people*. None of the respondents mentioned the tenants of the group homes unprompted, and when describing features of the new people of the neighborhood, they referred to *young people*.

Based on the theoretical constructs of social cohesion and social network (Berger-Shmitt 2000; Sluzki 1996) the degrees of interaction, relationship and mutual help between neighbors were analyzed. The percentages were equivalent in the study and control groups and the results showed that 47.8 % of the total sample considered that people in their neighborhood know each other *a lot,* and 49.1 % answered that they talk with *many* or *all* their neighbors. Furthermore, in the study group 57 % of people answered that they know each other *a lot*, but 25.8 % said they were aware of have a neighbor that had been in a psychiatric hospital.

Sixty-five percent of the respondents considered at least one of their neighbors to be a significant member of their social network. The situations in which the respondents

reported to have provided or received help from a neighbor were related to health (e.g., taking care of children when a parent is sick, visiting the neighbor at the hospital, calling an ambulance), security (e.g., watching the house in the absence of a neighbor, calling the police in the case of the presence of a suspicious person), and house improvement or maintenance (e.g., borrowing tools).

Based on the degree and depth of the relationship with the neighbors, a category *perceived social cohesion* was conceived, establishing a low cohesion when the interaction and relationship was not frequent or deep and high when it was. Six questions were used to build the category: (1).how much people knew each other in the neighborhood, (2) with how many neighbors greets, (3) converse, (4) have a close relationship, and (5) if they had helped or (6) were helped by a neighbor in case of need. Pre-defined values regarding to low or high perceived social cohesion were given to each question. The low or high social cohesion scores for each subject were assigned only when four or more of the six questions were labeled in that direction. If this requirement was not achieved, the subject was scored as having a neutral social cohesion.

The results showed that in the study group 6 % of respondents perceived a low social cohesion, 57 % neutral and 37 % high. For the control group 15 % perceived low cohesion, 52 % for neutral and 33 % for high. Chi square test was applied and the differences between groups are not statistically significant ($\chi^2 = 5.212$; v = 2; $p = 0.74$).

Attitudes Toward Specific Groups

The results showed a high level of acceptance for all the given groups—physical disabilities, mental illness and mental retardation—except for people with drug consumption. In the case of people with mental illness, 67.2 % of the study group and 57.5 % of the control group reported a high level of acceptance of this population, when *high* is defined as above seven in a scale from one (minimum value) to ten (maximum value). For comparing the study and the control groups' level of acceptance toward mentally ill people, the Chi square test was applied and its value was 15.813; v = 8; $p = 0.045$. In addition, high- and low-density neighbors' areas were compared, with higher acceptance toward mentally ill people found in the high-density area (80 %) than in the low-density one (61.3 %). Although the difference is not statistically significant, its value is close to it ($\chi^2 = 5.016$; v = 6; $p = 0.054$). A relationship between neighbors' acceptance toward the mentally ill and perceived social cohesion was found to be statistically significant ($\chi^2 = 10.637$ %; v = 4; $p = 0.031$) revealing that high acceptance toward the mentally ill was more frequent with neighbors who also had a high-perceived social cohesion.

Attitudes Toward Mentally Ill Persons, Their Treatment and Community Integration

Respondents were asked what they thought about people with mental illness and the answers were categorized according to the three components of attitudes: affective, behavioral and cognitive (Hogg and Vaughan 2005). Of the total sample, 46 % referred in their answer to *behaviors*, with no difference between the study and the control groups. The answers were grouped in six emerging categories: (1) Related with specialized treatment (30 %); (2) With help and assistance (26 %); (3) With no discrimination and social inclusion (19 %); (4) With contention and support (11 %); (5) With accompaniment (7 %); and (6) With comprehension and patience (6 %). No differences were found between the control and study groups. Inter-rated reliability for categories related to behaviors was 95.4 %

Regarding the *cognitive* component, 32 % of the answers were included in this category which was then sub-divided into three: (1) They are ill people (50 %); (2) They have different capabilities (25 %); and (3) They are like everybody else (25 %). Inter-rated reliability for these categories was 98.7 %. In this component, two statistically-significant differences were found between the two groups. Thirty-two percent of the study group and 68 % of the control group answered *they are ill people* ($\chi^2 = 11.218$; v = 1; $p = 0.001$). Seventy-nine percent of the study group and 21 % of the control answered that *they are like everybody else* ($\chi^2 = 7.402$; v = 1; $p = 0.025$).

Finally, 17 % of the answers were labeled as belonging to the *affective* component (inter-rated reliability: 90.9 %). The predominant affective valuation was related to compassion with 49 % of the answers (i.e. sadness, shame). It was observed that 31 % of answers referred to a negative affective valuation (i.e. a disgrace). Twelve percent of the answers were categorized as having a neutral affective valuation and 5 % as positive (i.e. loving, adorable). Only one person (2 %) refered to "fear" in the answer.

Attitudes toward treatment for people with mental illness were explored through an open question. Qualitative analysis showed that respondents knew about different treatment strategies. Of the total sample, 7.6 % mentioned *only* internment in their answer, while most other people who talked about internment also mentioned other strategies. Community treatment modalities were mentioned by 17 % of the study group and 11.8 % of the control. Inter-rated reliability for these categories was 96.6 %. Although the difference is not statistically significant, it is close ($\chi^2 = 8.458$; v = 10; $p = 0.0584$).

The respondents were also asked who should be involved in the treatment of the mentally ill. Family was the most frequently mentioned, followed by physicians.

Specialists or specialized physicians were included in some answers; 2.5 % of the respondents explicitly mentioned psychiatrists and even a lower percentage mentioned other specialists such as psychologists, psychoanalysts and neurologists. A low proportion of the sample included *the community* as an actor involved in the treatment and just one person mentioned *the neighbors.* Only two of the total sample mentioned *the patients themselves* as participants on their own treatment.

The opinion about neighbors' involvement in the recovery process of the mentally ill was also analyzed. No differences were found between the study and control groups (χ^2= 5.211; v = 6; $p = 0.517$). Nevertheless is important to mention that 41 % of the total sample answered that they could help being supportive and that 23 % answered that they could help in their inclusion, avoiding discrimination. The answers were general rather than specific (i.e. *help*, but without mentioning helping how or in which aspect). Inter-rated reliability was 96.2 %.

Finally the respondents were asked about the possible effects that discharged psychiatric patients might have on the neighborhoods in which they live. Inter-rated reliability for these categories was 97.9 %. Of the total sample 44 % said that it would not produce any effect and 11 % answered that they did not know. Also, 11 % said that it would cause concern or fear depending of the type or severity of the illness, referring specifically to an aggressive behavior of the person with a mental illness. The people who answered this were 23 % of the study group and 77 % of the control one, with a statistically significant difference ($\chi^2 = 8.195$; v = 1; $p = 0.005$). Ten percent of the total sample said that the presence of a mentally ill person would help the neighbors be more *supportive*, this being more commonly Finally, just 1 % of the answered in the study group than in the control one, but not statistically significant ($\chi^2 = 9{,}898$; v = 9; $p = 0{,}359$). total sample mentioned *awareness* as a possible effect.

Discussion

The presented results show a significant association between being a neighbor of a house with tenants with a mental illness and the degree of acceptance toward people with mental illness. There is also a statistically significant association between perceived social cohesion and the level of acceptance toward the mentally ill. Another association found was that neighbors, more frequently than non-neighbors, tended to think that people with mental illness are like everybody else. Some of the results are consistent with previous research's findings of an association between community life with people with mental illness and the degree of acceptance (Antos Arens 1993; Taylor and Dear 1981; Unger and Wandersman 1985), even though there is not an explicit consciousness of that coexistence (Rabkin et al. 1984; Unger and Wandersman 1985), and also that negative attitudes toward the mentally ill tends to be more frequent in areas in which there is not a facility than in those in which there is one (Cook 1997).

But although some differences were found between the study and the control groups regarding acceptance of the mentally ill, ideas about the mentally ill and concerns about their life in the neighborhoods, this data must be contrasted with the fact that only 25.8 % of the study-area respondents were aware that some of their neighbors had been patients in a psychiatric hospital. Although in the study area there were more *positive attitudes,* the fact that only a quarter of the respondents knew they had discharged neighbors makes it difficult to sustain that these attitudes are necessarily related to the proximity of the housing facility. Nevertheless, it is possible to conjecture that because the majority of the group homes have remained in the neighborhoods for several years, the neighbors did not recognize the presence of the tenants explicitly, and they have become, in a sense, a *common neighbor.*

Another result to be underlined is that negative attitudes are focused toward drug consumption. This rejection is probably related with the fact that this population is nowadays the one that is associated with aggressive behaviors and crime, which is seen—crime and public safety—by Argentinians as the most important problem of the Country (Corporación Latinobarómetro 2013).

One finding that differs from the existing literature on the topic is the association between social cohesion and acceptance toward the mentally ill. Although it is possible to maintain that the methodology used to explore social cohesion in this study was different than that used in other studies (Segal and Aviram 1978; Taylor et al. 1979)—with more emphasis in this one on the frequency and depth of the social interaction between neighbors—the basic dimensions and features of social cohesion are similar, in terms of mutual knowledge. A mentioned before, it was found here that high-perceived social cohesion associates with a highlevel of acceptance. This finding needs to be explored more in-depth in future studies, but would be hypothesized that cultural features of social relationships and interactions are involved.

An aim of this study was to explore the positive effects of community life with people with mental illness. Based on current results, 11 % of the total sample mentioned some positive effect, the most frequent being to become more supportive of people with mental illness (10 %). It is a low percentage of the total sample, but this is likely related to the fact that other methodological strategies or more specific questions on this topic were not in place. Nevertheless, it is important to note that more than half of the total sample answered that living near people with mental illness would not produce an effect. The finding that

that negative effects are not frequently expected by the community is helpful for policy-making discussions. Also, the *supportive* effect finding needs further and deeper exploration, but is an intriguing topic because the few existing studies that analyze the positive effects on communities (Antos Arens 1993; Cook 1997) are focused on aspects such as tolerance and education, which could be seen as more individual effects, but *support* refers more to possible community and social network level effects.

Finally, the fact that the common citizen is aware of different care strategies is important for the policy-making process in Argentina where a National Mental Health Law was enacted recently, and where there is still resistance from some professionals and other sectors in terms of the transformation of the psychiatric institutions. The fact that the community has a broader perspective of the care process for people with mental illness is an important argument for the discussions about the reform.

It is important to mention that a possible limitation of this research was that the definition of the study area was too broad, and that would have led to a misidentification of possible differences between the study and the control groups in certain aspects. Based on this a further project that includes other discharge programs will correct this limitation by defining the study area more accurately (e.g., the same block of the housing facility). Also, although the questionnaire was useful to explore some aspects and open some questions, it would be needed to be combined with other methodological tools in order to explore more in-depth certain aspects such as *acceptance* and the *positive effects* of community life with people with mental illness. For instance, besides including neighbors it would be useful to speak with patrons of privileged places of social interaction in neighborhoods such as the grocery stores. Another limitation of the study was the modest sample size, which is intended to be corrected with a larger study for the whole Province of Buenos Aires and its different housing experiences for psychiatric patients.

As a whole, based on the present study it can be concluded that community life with people with mental illness is associated with increased acceptance of mental illness, and that this is present in different cultural contexts. Also, the association between acceptance toward mentally ill people and social cohesion must be considered according to specific cultural patterns and values related to social relationships and social interaction.

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