Mental Health and Poverty in the Inner City

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Rapid urbanization globally threatens to increase the risk to mental health and requires a rethinking of the relationship between urban poverty and mental health. The aim of this article is to reveal the cyclic nature of this relationship: Concentrated urban poverty cultivates mental illness, while the resulting mental illness reinforces poverty. The authors used theories about social disorganization and crime to explore the mechanisms through which the urban environment can contribute to mental health problems. They present some data on crime, substance abuse, and social control to support their claim that mental illness reinforces poverty. The authors argue that, to interrupt this cycle and improve outcomes, social workers and policymakers must work together to implement a comprehensive mental health care system that emphasizes prevention, reaches young people, crosses traditional health care provision boundaries, and involves the entire community to break this cycle and improve the outcomes of those living in urban poverty.

KEY WORDS: *health and environment; health promotion; mental health; social policy; urban health*

Globally, the number of people who reside in cities is rapidly increasing. In 2007, more than half the world's population lived in urban areas, and steady increases were projected for future decades (Freudenberg, Galea, & Vlahov, 2006). Scholars have observed that "some of the best-established effects of urbanization concern mental health" (Lederbogen et al., 2011, p. 498). Meta-analyses provide evidence that those who live in cities have a higher risk for mood disorders, anxiety disorders, and schizophrenia (Lederbogen et al., 2011). At some point in their lives, 46 percent of Americans will experience at least one disorder listed in the DSM-IV (Kessler et al., 2005). The conceptual framework for this article is based on a pragmatist view of the relationship between social structure and outcomes and the importance of evidence-based policy and program reform to address urban social problems.

The relationship between mental health and urbanization is complex. Traditionally, some scholars have pointed to the role of the urban physical environment. Exposure to noise and lack of adequate green space—key features of the urban environment—can cause psychological distress, hypertension, and hearing impairment (Chang, Jain, Wang, & Chan, 2003; Freudenberg et al., 2006). Mental health problems are disproportionately manifested among the urban poor. The poverty that is characteristic of certain areas in the urban environment not only contributes to the prevalence of mental illness but also is created and entrenched by mental illness. We argue that the relationship between mental health and the urban environment is not linear but cyclical and reinforcing. The poverty of the urban environment cultivates mental illness, while the resulting mental illness reinforces urban poverty. To interrupt this cycle, social workers and policymakers must implement a comprehensive mental health care system that emphasizes prevention, reaches young people, crosses traditional health care provision boundaries, and involves the entire community.

In this article, we use theories about social disorganization and crime to explore the mechanisms through which the urban environment contributes to or harms an individual's mental health. Then we use information about crime, substance abuse, and social control to support our claim that mental illness reinforces poverty. As a response to the bidirectional relationship between mental health and urban poverty, we recommend a series of mental health interventions that mobilize a variety of institutions and individuals within the community to promote improvements in mental health.

URBANIZATION, POVERTY, AND MENTAL HEALTH

Different mechanisms are important for explaining the relationship between city living and mental health disorders. Among these are socioeconomic disparities (Wilkinson & Pickett, 2010), poverty

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(Belle, 1990), the presence of residentially unstable populations, dense and diverse populations, high crime rates, and social disorganization (Freudenberg et al., 2006). Each of these subjects city dwellers to substantial stress. For example, spatial segregation along racial, ethnic, or socioeconomic lines reinforces poverty for low-income residents. The forced homogeneity of these social network ties often precludes spatial proximity of poor urban youths to edifying role models. Yet socioeconomically disadvantaged people require more diverse social ties to improve their socioeconomic status (SES). Segregation is also unfortunate because it does not allow the formation of social networks that would result in employment or social mobility (Freudenberg et al., 2006). Many of the risk factors discussed may be cumulative, increasing vulnerability to mental health issues among low-income inner-city children and youths (Evans, 2004).

Joblessness and Underemployment

In *When Work Disappears*, William Julius Wilson (1997) made a connection between urban poverty and mental health when he asserted that unstable work and low income decrease one's perceived self-efficacy. A recent meta-analysis found that indebtedness is one mediating factor between poverty and poor mental health (Fitch, Hamilton, Bassett, & Davey, 2011). Another study completed in Philadelphia supported these findings by revealing the adverse effects of economic pressure on mental health and parental behavior, based on a sample of black and white inner-city parents (Elder, Eccles, Ardelt, & Lord, 1995). The research revealed that mounting economic pressures, caused by unstable work and low income, created feelings of emotional distress and, as a result, tended to lower the parents' sense of efficacy regarding what they believed to be their influence over their children and their children's environment. Perceived ineffectiveness was particularly magnified among African American families, single-parent households, and conflicted marriages, undermining parent well-being. Particularly among African American families, a sense of parental self-efficacy is predictive of child management strategies that enhance developmental opportunities for children and minimize behavioral risks (Elder et al., 1995). This means that financial stability can play an important role in determining a child's mental health. Different neighborhood characteristics can support mental health resilience or negative outcomes (Wandersman & Nation, 1998).

Neighborhood Disorder

The extent of an individual's perceptions of neighborhood disorder has also been found to significantly affect levels of mental distress (McKenzie & Harpham, 2006). In a 2003 study, researchers examined the relationship between perceptions of one's neighborhood, levels of social support and social integration, and level of subsequent depressive symptoms among 818 individuals screened for an HIV prevention intervention, most of whom were current or former drug users. Data from a follow-up interview nine months after the intervention illustrated that negative perceptions of neighborhood characteristics (including drug sales, litter, vacant housing, teenagers loitering, and robbery) predicted depressive symptoms.

The Epidemiologic Catchment Area Study, the largest community mental health survey ever conducted in the United States, corroborated these findings in a study of 20,000 adults in five communities, to estimate the prevalence and incidence of specific psychiatric disorders in a sample of institutionalized and noninstitutionalized individuals. The study reported that there is an inverse relationship between socioeconomic position and psychiatric disorders (Yu & Williams, 1999). The data support the theory of social disorganization and hint at the need for a broad structural intervention. As neighborhood disorder is a powerful chronic stressor, it may even be possible to identify entire neighborhoods in which all residents are at an elevated risk for depression (Latkin & Curry, 2003).

The mechanism that explains the link between perceived neighborhood disorder and mental well-being is a complex one with important implications. Neighborhoods with high levels of disorder indicate to residents, by means of visible signs and cues, a lack of social control. While some residents do not respect property or their neighbors, traditional agents of control are unwilling or unable to cope with local problems. At worst, the neighborhood has been abandoned, and its inhabitants must fend for themselves (Hill, Ross, & Angel, 2005).

Disorder is a signal of perceived threat. An environment in which residents report muggings, assaults, gangs, drug use, inadequate police protection, unsupervised youths, and other forms of social disorder may undermine physical health by

several pathways, including a psycho-physiological stress response (Hill et al., 2005). Such physiological responses may be experienced as rapid heartbeat, trouble breathing, upset stomach, sweating, dry mouth, and numbness or tingling in one's limbs (Hill et al., 2005). Hill et al. supported this model using data from the Welfare, Children, & Families: A Three City Study, which studied 2,402 women in disadvantaged neighborhoods in Chicago, Boston, and San Antonio. The study concluded that psychological and physiological stress responses to ongoing danger, dilapidation, drugs, and neglect in a neighborhood mediate the association between neighborhood disorder and health.

The same data were also used to show that residents of disadvantaged neighborhoods drink more heavily than residents of more affluent neighborhoods (Hill & Angel, 2005). Again, perceptions of neighborhood disorder were shown to often result in the development of mental health conditions—in this case, heavy drinking and addiction. The stress of living in a neighborhood characterized by drug abuse, crime, unemployment, abandoned houses, teenage pregnancy, idle youths, and unresponsive police can be psychologically distressing and lead some people to consume alcohol in hopes of alleviating feelings of anxiety and depression (Hill & Angel, 2005). Hill and Angel found that the positive association between neighborhood disorder and heavy drinking is largely mediated by anxiety and depression, thereby demonstrating that the stress of living amid concentrated urban poverty can lead to further manifestations of mental health problems. Hill et al. (2005) noted that the disadvantaged get stuck in disadvantaged neighborhoods with few routes of escape and are thus the most susceptible to the mental illness that results from neighborhood disorder. This vulnerability is exacerbated by the fact that low-income youths have greater access to alcohol than do youths in middle-income neighborhoods (Levanthal & Brooks-Gunn, 2000).

CHILDREN'S MENTAL HEALTH AND POVERTY

The impact of poverty and social disadvantage on children's health is further evidence that poverty is a serious risk factor for mental illness. Low-income children disproportionately suffer from deficits in cognitive skills and educational achievement (Harding, 2010; Murali & Oyebode, 2004). Hunger increases risks to health and mental health (Weinreb et al., 2002). Behavioral problems, such as attention deficit/hyperactivity disorder, are also linked with family poverty. They are most pronounced among children whose families face persistent economic stress (Murali & Oyebode, 2004). Poverty can cause stress and result in depression in children because stressful social environments affect the biology of the brain in ways that can become serious if left untreated (Hernandez, Montana, & Clarke, 2010). Economic insecurity can also affect the mental health of parents, causing anxiety, psychological distress, and depression. These mental dispositions influence their interactions with their children, thereby influencing their children's mental health (Hernandez et al., 2010).

Mediating Role of Crime and Insecurity

Crime is also a major component of poverty in the urban environment that mediates a relationship between city living and mental illness. Isolated episodes of violence coupled with chronic exposure to violence can prompt a variety of emotional reactions from adults and children alike. Many of these are symptoms of posttraumatic stress disorder (PTSD) (Marans et al., 1995). Research suggests that urban poverty contributes to mental illness. For example, in the Moving to Opportunity (MTO) housing mobility experiment, public housing residents in five cities were randomly assigned to a control group and two treatment groups, one that was given rent vouchers that could be used only in *low-poverty* neighborhoods (defined as less than 10 percent poverty) and one that received unrestricted vouchers (Harding, 2010). The researchers assessed the effects of the rent vouchers by examining the neighborhoods into which families in the treatment groups moved and outcomes such as health, education, employment, and criminal behavior. Some important differences were detected between the treatment groups and control group at the evaluations that took place five to seven years later. The differences found were primarily related to mental health, stress, and safety; these differences favored youths who moved to low- to middle-income neighborhoods rather than those who remained in public housing in poor neighborhoods (Harding, 2010). A reevaluation of the MTO data found that girls in families who remained in low-income neighborhoods for longer periods had better mental health

(and engaged in fewer) risky behaviors than the control group (Leventhal & Dupéré, 2011). In another study involving a nonrepresentative sample of New York City high school youths, exposure to violence was significantly related to a higher incidence of depression and hostility (Moses, 1999).

A review of research on the effects of neighborhood residence on child and adolescent well-being found that a number of national and regional studies suggest that residing in neighborhoods of low SES is associated with higher rates of criminal and delinquent behaviors. This review also cited the Yonkers Project, in which adolescents who remained in low-income neighborhoods were more likely to show signs of problem drinking and marijuana use than youths who moved to middle-income neighborhoods (Levanthal & Brooks-Gunn, 2000). Another study found that youths in low-SES neighborhoods perceived greater danger than their peers in high-SES neighborhoods and that this perception negatively influenced their mental health. Low-SES children and children from single-parent families were most likely to be exposed to aggressive peers in the neighborhood (Levanthal & Brooks-Gunn, 2000).

Several quantitative studies have reported that the quantity and behavior of one's peers both mediate and moderate neighborhood effects (Levanthal & Brooks-Gunn, 2000). In socially disadvantaged neighborhoods, fewer informal and formal social networks exist for youths, which may be associated with delinquency, problem behavior, prosocial competence, and negative peer group affiliation. Peer deviance, often in the form of violence, mediates the negative effect of neighborhood disadvantage in adolescents' mental health (Levanthal & Brooks-Gunn, 2000).

Efficacy

The potential for exposure to violence to result in mental health outcomes such as PTSD and depression is likely linked to the increasing perceptions of powerlessness and feelings of diminishing self-efficacy that are caused by violence and neighborhood disorder. Research has shown that, at the individual level, higher SES directly promotes a sense of efficacy, control, and even biological health. It is possible that, at the community level, the alienation, dependency, and exploitation caused by resource deprivation inhibit collective efficacy, which is social cohesion among neighbors and their willingness to intervene for the public good (Sampson, Raudenbush, & Earls, 1997). Sampson and colleagues presented the theoretical underpinnings to explain how racial and economic exclusion influence perceived powerlessness and mental health in disadvantaged neighborhoods. They also explained that collective efficacy mediates much of the association of residential stability and disadvantage with multiple measures of violence (Sampson, Raudenbush, & Earls, 1997). Individuals who feel powerless are unlikely to intervene in an effort to reduce violence in the neighborhood.

CONSEQUENCES OF URBAN VIOLENCE AND VICTIMIZATION

Emotional responses to violence among individuals in disadvantaged neighborhoods can take on a number of different forms. Repeated exposure to violence may lead to persistent patterns of psychological withdrawal, depression, and social disengagement (Marans et al., 1995). Based on his research on boys in low-income Boston communities, Harding (2010) argued that there is a physiological mechanism by which the prevalence of violence within disadvantaged neighborhoods yields serious mental health problems, as chronic stress results in biological responses that undermine self-efficacy:

> Long-term experience of chronic stress created by exposure to violence and threat of victimization can have physiological consequences . . . [and] can influence cognitive functioning by inhibiting the formation of connections between neurons in the brain and by impairing memory. . . . [It] can also lead to greater aggressiveness, impulsivity, anger, and susceptibility to substance use. . . . These biosocial consequences of violence—poor cognitive development, risk taking, and substance use—may in turn increase the risk of school dropout or teenage pregnancy. (Harding, 2010, p. 281)

The threat of violence, when combined with joblessness, substandard housing, and inadequate schooling, causes individuals to develop even stronger feelings of powerlessness (Marans et al., 1995).

PTSD

The psychological distress caused by trauma and violence in areas of concentrated urban poverty often takes the form of PTSD. Therefore, it is essential that any thorough analysis of mental health in the inner city address this disorder. PTSD prevalence is 9 percent to 12 percent in the general population, but it is most likely higher among residents of urban, economically disadvantaged areas because this population is at higher risk than the general population of exposure to traumatic events (Schwartz, Bradley, Sexton, Sherry, & Ressler, 2005). There is a greater risk of victimization among inner-city residents because of low SES and high rates of violence. Therefore, trauma is often underrecognized, and PTSD is often underdiagnosed (Schwartz et al., 2005). This is especially detrimental in light of findings from a study that examined African American outpatients in an inner-city mental health clinic. The study reported that individuals with PTSD are more likely to have worse clinical and quality-of-life characteristics, such as nonschizophrenic psychosis and depression (Schwartz et al., 2005). PTSD was also associated with high rates of suicide attempts and comorbid substance use and depression (Schwartz et al., 2005; Valera, Sawyer, & Schiraldi, 2001). The study suggested that the extent of previous trauma is significantly correlated with PTSD symptom severity (Schwartz et al., 2005).

These findings are supported by another study involving women recruited from two obstetrical-gynecological clinics serving low-income women in a midsize midwestern city. Most participants were African American, in their early 20s, single, unemployed, and had one child (Schumm, Briggs-Phillips, & Hobfoll, 2006). The study demonstrated that effects of interpersonal trauma are cumulative such that women who experienced either child abuse or adult rape were six times more likely to have PTSD, whereas women who experienced both child abuse and rape were 17 times more likely to have PTSD (Schumm et al., 2006). Another study examined reported levels of violence and assessed the existence of PTSD among 100 female, male, and transgender male prostitutes in inner-city Washington, DC (Valera et al., 2001). During their involvement with prostitution, over 60 percent of the participants had experienced violence and 44 percent had been raped; 42 percent met established criteria for PTSD.

Responses to Trauma

Street sex workers who are exposed to violent acts almost every day are at an even greater risk than the general public for psychological distress (Valera et al., 2001). Thus, there is a need to acknowledge the presence and influence of PTSD when designing and implementing interventions for them. The same can be said for African Americans and other predominantly low-income groups in response to other studies that have focused on PTSD in the inner city.

These findings constitute a major urban social problem because they suggest that trauma is a common experience for low-income residents of the inner city. Social workers and other practitioners should acknowledge the extent and significance of PTSD and the accompanying complications that might impede successful interventions. For example, avoidance, one of the symptoms of PTSD, can lead to avoidance of emotional ties with social workers and other practitioners trying to assist clients with PTSD (Valera et al., 2001). Policymakers must also invest greater resources in improving inner-city mental health services and supports.

POVERTY AND MENTAL HEALTH: A BIDIRECTIONAL RELATIONSHIP

The relationship between SES and mental health is bidirectional, with poverty often leading to mental illness and mental illness regularly reinforcing poverty. The criminal justice system exemplifies this relationship. A high percentage of the mentally ill are arrested, and this perpetuates poverty for those within that population. Incarceration reduces the potential for future employment (Clark, Ricketts, & McHugo, 1999; Pager, 2007). Longitudinal survey data on a cohort of young men suggest that youth incarceration is associated with a 25 percent to 30 percent decline in the average number of weeks worked annually. Although a third of this decline can be attributed to recidivism, a substantial portion of it is associated with the far-reaching effects of incarceration (Pager, 2007). Another study found that youth incarceration reduces employment by more than 5 percent, with effects that continue even 10 to 15 years after incarceration (Pager, 2007). The role of incarceration in trapping individuals in poverty has especially important implications for mentally ill individuals living in the inner city.

Addiction

Many people who are arrested struggle with addiction. Clark et al. (1999) followed individuals with co-occurring severe mental illness and substance abuse disorders for three years to better understand various aspects of their involvement with the legal system. Their findings indicated that effective treatment of substance abuse among individuals with mental illness reduces incarcerations and arrests, supporting the bidirectional model of the poverty–mental health relationship (Clark et al., 1999).

Depression and Aggression

Symptoms of mental disorders can also increase the risk of impulsive and aggressive behaviors among adolescents. Research on young delinquent populations has demonstrated that youths with mental disorders are at greater risk of engaging in behaviors that result in entanglement with the juvenile justice system (Grisso, 2004). Depression is associated with adolescent aggression; previous exposure to violence and victimization, which is common in low-income urban settings, was the strongest predictor of an adolescent's own violent behaviors (Moses, 1999).

Systemic Failure

Deficiencies in the child and youth mental health system appear to be responsible for bringing many youths with mental disorders into the juvenile justice system. Two-thirds of youths in the juvenile justice system meet the criteria for one or more mental disorders. The prevalence of young people with mental health problems in the juvenile justice system indicates that mental illness, through involvement in crime, predisposes many teens with mental disorders to low occupational achievement and SES (Grisso, 2004). Adolescents in low-income urban neighborhoods who suffer from mental illness may also be headed toward poverty by means of a complex biosocial pathway in which exposure to violence causes them to experience slowed cognitive development, poor academic achievement, and difficulty in forming relationships. These are all risk factors for high school dropout and subsequent poverty during adulthood (Harding, 2010).

MENTAL HEALTH AND URBAN POVERTY

Because of the bidirectional relationship between mental health and urban conditions (primarily crime and poverty), it is most accurate to describe this relationship as cyclic. This cyclic relationship can be seen in low-income children who are exposed to violence in an urban neighborhood and experience psychological distress as a result of the trauma. Clearly, living in urban poverty influences their mental health. Over time, they are likely to become involved in delinquent and violent activities as a means of organizing their sense of self (Marans et al., 1995). Traumatic stress caused by exposure to violence can harm ego development, foster impaired identity formation, and result in low self-esteem. Identity can become distorted to embody criminality and violence because these children and adolescents perceive these as markers of adulthood (Moses, 1999). Moses (1999) argued that "it is widely accepted that personal characteristics such as gender influence risk-taking behaviors, exposure to violence, and the manner in which individuals respond to traumatic stress" (p. 22). Although boys and men have a greater likelihood of being exposed to neighborhood violence, girls and women are more likely to demonstrate increased symptoms of depression and hostility (Moses, 1999). By engaging in violent activities that are typical of their surroundings, children and adolescents reinforce the nature of the urban environment and may limit their opportunities for formal employment as a result of incarceration and criminal records (Marans et al., 1995). Thus, the relationship between mental health and urban poverty comes full circle.

This circularity is also embedded in the social disorganization mechanism. High levels of social organization within communities usually protect residents against stress and illness (McKenzie & Harpham, 2006). However, most inner-city neighborhoods have relatively low levels of social organization, as exemplified by a lack of formal organizations, resource-poor social networks, low levels of responsibility for community issues, and minimal involvement in community organizations (McKenzie & Harpham, 2006). Ultimately, social disorganization reinforces poverty and further disorganization. In U.S. cities, low-income residents, who endure the most exposure to stressors and experience a greater need for mental health resources, have less access to treatment than their wealthier counterparts (Freudenberg et al., 2006).

ADDRESSING THE CHALLENGE: COMMUNITY MENTAL HEALTH CARE COALITIONS

In light of the complex relationship between mental health and urban poverty, cities need a comprehensive mental health care system that will interrupt the poverty–mental health relationship. In such a system, partnerships can be developed between "parents, agencies, and institutions and federal, state, and local systems to meet needs of these children and their families" (Marans et al., 1995, p. 9). It must also be centered on the community. Social workers can and should play an important role advocating for and building coalitions to generate pressure and political will to create and implement these community-based programs.

A strong, comprehensive mental health care system should also emphasize child and adolescent mental health. It is also important to include young people in well-planned, school-based mental health interventions (Marans et al., 1995). The new system should break down traditional boundaries in health care provision and involve parents and the community in identifying children who are at high risk of mental health issues and providing treatment (Marans et al., 1995). For example, instead of relying exclusively on mental health professionals, social workers should help train teachers, police officers, coaches, and pastors to serve as allies. As partners with mental health professionals, social workers and other practitioners should be an integral part of the effort to interrupt the cycle of poverty and mental health (Marans et al., 1995). These programs should address risks and improve resiliency (Doll & Lyon, 1998).

Reducing Barriers to Access

In the inner city, there is a clear need not only for mental health care, but also for reducing barriers to access. Two-thirds of children who need mental health services are never connected with them (Brauner & Stevens, 2006). Urban minority children are at high risk for the development of a wide range of mental health problems but are the least likely to come in contact with service providers or receive relevant interventions (McKay, Nudelman, McCadam, & Gonzales, 1996). Among those who do meet with a service provider, the most vulnerable children, in terms of seriousness of mental illness or complexity of social situation, are the least likely to return after an initial mental health care session (McKay, Nudelman, et al., 1996).

Evidence-Based Approaches

Empirical findings can provide a strong basis for restructuring urban child mental health service delivery systems. Research has demonstrated that one key strategy in overcoming barriers to access is training urban service providers to engage families in child mental health services. In this context, engagement refers to the process in which a child is identified as experiencing mental health problems and then receives appropriate and sufficient mental health care (McKay & Bannon, 2004). It is critical that social work educators assist social workers in developing "focused, culturally sensitive engagement skills that address the range of barriers that can exist within families, urban environments, and agencies interfering with the process of engagement" (McKay, Nudelman, et al., 1996, p. 463). The family associate engagement strategy, for example, was designed to provide customized outreach and support to low-income families with children in need of mental health care (McKay & Bannon, 2004). Family associates were trained to encourage such families to connect their children with mental health resources and to continue with the recommended services. They provided families with emotional support, information, and help in overcoming specific barriers, such as the inability to access child care or transportation. This strategy was effective in promoting continued contact between families and the child mental health service delivery system. McKay, Lynn, and Bannon (2005) also found strong evidence that intensive engagement strategies employed during initial contacts with children and their families can substantially increase use of services. Social workers should reach out to and work with families to overcome barriers to youths receiving mental health care.

Overcoming Mistrust: Care Alliances

One explanation for the large gap between mental health care need and treatment participation in impoverished urban communities is that there is a mistrust of outsiders, including many of the people providing mental health care or conducting research (McKay & Bannon, 2004). To close the gap and maximize use of mental health resources in these communities, collaborative research efforts between researchers and clients may help to create alliances and increase the relevance of services. These alliances may create a better understanding

of the challenges families face and how difficulties related to engaging families in services may be addressed (Harrison, McKay, & Bannon, 2004; McKay & Bannon, 2004). It is essential that child mental health agencies and providers consider input from families when evaluating service delivery options or targeting specific barriers to care. Social workers should foster linkages between service providers and clients in collaborative research efforts and use the data to improve the effectiveness of services.

School-Based Services

School-based health centers (SBHCs) are another essential component of the kind of comprehensive system that is needed to overcome the structural barriers present in areas of urban poverty. Because about half of Americans will meet the criteria for a DSM-IV disorder sometime in their lives, with initial onset usually during childhood or adolescence, interventions aimed at prevention or early treatment should be focused on youths (Kessler et al., 2005).

SBHCs facilitate access to preventive health services and educate young people about activities and behaviors that promote well-being. Extending the services of SBHCs to parents and caregivers could increase the accessibility and availability of school programs for the broader community. Schools are an ideal venue for selective or universal interventions (Black & Krishnakumar, 1998). SBHCs are also more accessible to students than traditional community mental health services because they decrease stigma, support more comprehensive services, and increase efficiency by providing services at a location in which students are available (Rappaport, 2001).

SBHCs also have the potential to address teachers' limitations in dealing with mental health issues in the classroom. In a recent study, teachers from six elementary schools in a major midwestern city were surveyed about their feelings regarding mental health service needs in inner-city elementary schools. Half of the teachers reported disruptive behavior as the largest mental health problem at their schools and identified a lack of information or training as the greatest obstacle to overcoming mental health problems. Although most of the teachers surveyed had taught students with mental health problems at some point, most had had little mental health education and minimal consultation with mental health professionals. As a result, the teachers' knowledge of these issues was inadequate, and they were not confident about their capacity to deal with them (Walter, Gouze, & Lim, 2006).

An intelligently conceived SBHC that includes child mental health services would provide teachers with access to information about mental health disorders and treatments and train them to manage mental health problems in the classroom. The programs should aim to provide role models and resources to increase mental health resilience to combat the deleterious effects of low SES (Chen & Miller, 2012). One pilot study of the implementation of comprehensive mental health services at two inner-city elementary schools demonstrated impressive program effects and satisfaction after the first year (Walter et al., 2011). Another pilot study found school-based mental health programs to have greater retention than neighborhood health centers and positive effects on behavior and academic performance (Atkins et al., 2006).

Adolescence is a time when youths in low-income households are particularly vulnerable to mental health challenges, but it also provides intervention opportunities (Dashiff, DiMicco, Myers, & Sheppard, 2009). Before the dramatic increase from two SBHCs in 1970 to 1,200 in 2000, many students across the United States did not use traditional sources of health care, such as annual doctor visits. Instead, they relied on sporadic emergency room visits for medical care (Rappaport, 2001). On average, 60 percent of students in schools with an SBHC enroll for services, and 70 percent of enrolled students use them (Rappaport, 2001). Trained counselors and psychiatrists should be present at SBHCs, because this would expand the service offerings to include mental health care services; psychiatrists would be able to carry out therapy, assessment, and psychopharmacology (Rappaport, 2001).

The establishment of comprehensive mental health services in schools could be very effective in reaching disadvantaged children who would otherwise not have access to these services. A comprehensive mental health pilot program was recently carried out in two inner-city public schools in a major midwestern city (Walter et al., 2011). After one year, students covered by the program had significantly fewer mental health difficulties, less functional impairment, and improved behavior. They reported improved mental health knowledge,

attitudes, beliefs, and behavioral intentions. Teachers were also more proficient in managing mental health problems in their classrooms (Walter et al., 2011).

Armbruster and Lichtman (1999) reported similar findings when they evaluated mental health services in 36 schools established by a university-affiliated children's mental health outpatient clinic. The results indicated that school-based mental health services show improvement comparable to the clinic-based services and have the potential to minimize the gap between service need and utilization by engaging low-income children who would otherwise be unable to access mental health services. Teachers attested that students engaged in the services had improved overall functioning, and school personnel reported that academic performance, behavior, and attendance had improved. Such school-based interventions would be an appropriate response to studies that have identified urban, disadvantaged, minority children from single-parent homes as the most at risk for prematurely cutting off clinic contact (Armbruster & Lichtman, 1999). Social workers should advocate for the expansion of SBHCs and other school-based services, especially counseling and mental health services.

Urban Churches and Pastoral Care

Pastoral care can also be an important feature of a comprehensive mental health service plan. Social workers and other practitioners should engage and train urban clergy and lay ministers to provide short-term counseling and referrals for longer term mental health care. Clergy represent a significant mental health resource for people who otherwise lack sufficient access to care. This approach also builds on the central role of the church in many Hispanic and African American families and communities (Young, Griffith, & Williams, 2003). A similar model could also be extended to Jewish and Islamic religious leaders.

Addressing the Needs of the Homeless

A number of effective policy-level interventions can be used in cities to address the high levels of mental illness within the homeless population. Chief among these is the "housing first" approach, which includes the placement of homeless individuals with severe mental disabilities in supportive housing as the first step in treatment. An evaluation of the work of one such program in New York City between 1989 and 1997 revealed that people placed in such housing experienced marked reductions in shelter use, time incarcerated, hospitalizations, and length of stay per hospitalization. Placement in safe and secure housing was accompanied by improvements in mental health and a $16,281 reduction in public funds spent per person per year (Culhane, Metreaux, & Hadley, 2002). Social workers should advocate at all levels of government for housing-first policies.

Reevaluating Urban Mental Health Services

Given the urgent need for more accessible mental health services, health care delivery systems in cities need to be reevaluated. Using mental health care to improve mental well-being, while at the same time rebuilding a sense of community efficacy in areas of urban poverty, requires deeper changes than just mental health intervention. Mobilization to advocate for social policies including employment, housing, and social services is also needed (Latkin & Curry 2003). Social workers should mobilize coalitions across sectors involving agencies, organizations, and individuals to address contextual barriers to effective mental health care for low-income urban communities. Such a comprehensive intervention could put an end to the continual inner-city cycle in which mental disorder and social disorder fuel each other.

CONCLUSION

As a result of stressors present in the urban environment, those living in cities are at greater risk of developing mental disorders than those living in suburban and rural areas. Those who experience the highest risk of mental disorders are disadvantaged populations within these urban communities. As a result of the complex forces that come together amid concentrated urban poverty, there exists a bidirectional, cyclic, and reinforcing relationship between poverty and mental illness in the inner city. Social disorder and violence, by undermining efficacy and promoting feelings of powerlessness, are key agents in perpetuating this relationship. In order to interrupt the cycle and achieve progress, social workers need to work with community stakeholders to implement a comprehensive mental health care system that crosses traditional health care provision boundaries by mobilizing a variety of community institutions

(including schools, churches, and law enforcement) and professionals (including social workers, teachers, pastors, and police) to overcome barriers to accessing mental health care services. In light of the relationship between SES and mental illness, the development of effective interventions that address urban mental health could also help reduce urban poverty and social problems. Advocacy by social workers to mobilize cross-sectoral coalitions and the political will to create policies and programs to address barriers to mental health care service provision in inner cities are crucial for improving mental health and reducing urban poverty and dislocation. **HSW**

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