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ORIGINAL ARTICLE

Definitions of Community for Individuals with Serious Mental Illnesses: Implications for Community Integration and Recovery

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Abstract

While recent work on community integration for individuals with serious mental illnesses (SMIs) has focused on the multi-dimensionality of community integration, it has not been fully rooted in how consumers define and experience communities *for themselves*. Guided by symbolic interactionism theory, the goal of the present study is to explore definitions of community as provided by individuals with SMIs, and to incorporate those definitions into a theoretical framework of community to inform community integration efforts in the context of mental health services and recovery. Semi-structured interviews were conducted between November 2017 and September 2018 with 90 racially/ethnically diverse participants who were 18 years and older with an SMI and receiving community mental health services. Interviews were audio-recorded, transcribed, and analyzed using ResearchTalk's "Sort and Sift, Think and Shift" methodology. Themes derived from participants' definitions of community included a structural aspect of people and places; a functional aspect of socializing, helping and receiving resources; and an experiential aspect of shared struggles and experiences, finding safety, and identifying with others. To this end, we propose a *Structural, Functional* and *Experiential* (SFE) model of community. The SFE model of community provides a conceptual framework and guidance for clinicians, researchers, policy makers and service stakeholders regarding the complexity and variability of community for their consumers, which is essential to their recovery. Application of the SFE framework for assessment and intervention is discussed.

Keywords Communities · Community integration · Community definitions · Serious mental illnesses

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Introduction

Community integration for individuals with serious mental illnesses (SMIs) is often defined as the physical, psychological and social aspects of community participation, social connections and belonging (Wong and Solomon 2002). It is simultaneously recognized as the "external, concrete manifestation" of recovery (Bond et al. 2004, p. 571), an important outcome of mental health treatment (Finnerty et al. 2015; Pahwa et al. 2014), and a challenge for individuals with SMIs (Townley et al. 2009). Community integration has been shown to facilitate recovery for individuals with SMIs by positively impacting social relationships, life satisfaction and quality of life, while also reducing social isolation, mental health symptomatology, and stigma (Bredewold et al. 2018; Finnerty et al. 2015; Townley et al. 2013). Accordingly, community integration is a commonly used treatment target of mental health services; however, these efforts are built on the presumption that "community," and hence community integration, has a universal meaning (Wong et al. 2014). But decades of literature include more than 90 definitions of community which suggests that this concept has disparate meanings across scholars and disciplines (Brennan and Brown 2008; Hillery 1955; Tyler 2006).

While recent work on community integration for individuals with SMIs has focused on the experience and multi-dimensional nature of community integration (Bromley et al. 2013; Pahwa et al. 2014; Wong et al. 2010, 2014), it has not been fully rooted in how consumers define and experience communities *for themselves.* Hence, efforts to strengthen community integration among individuals with SMIs could have limited relevance and impact on their lived experiences. The experience of mental illness not only shapes individuals' community preferences but also the ways people experience their communities (Bromley et al. 2013) and the process of community integration. The goal of the present study is to explore definitions of community as provided by individuals with SMIs, and to incorporate those definitions into a theoretical framework of community to guide community integration efforts in the context of mental health services and recovery.

Conceptualizations of community and community integration for individuals with SMIs began with the passage of the Community Mental Health Act of 1963 and the subsequent deinstitutionalization movement, through the Mental Health Parity Act of 2008 (Barry et al. 2010). A main goal of these efforts was to create effective community-based mental health treatment and reintegrate individuals with SMIs into their communities. However, service programs were inadequately funded and had unrealistically high expectations that medication was a panacea for individuals who had been hospitalized for decades (Gronfein 1985). The result was the "revolving door" phenomenon: formerly institutionalized patients cycled in and out of state psychiatric hospitals (Lauer and Brownstein 2008). Consequently, homelessness among individuals with SMIs increased (Dear and Wolch 2014), which may explain the focus of most of the current interventions that target the physical aspects of community integration via housing services.

Theoretical Framework

Scholars have defined community in various ways including: a place, neighborhood, or other physical loci of society (Brennan and Brown 2008; Tyler 2006); a symbolically constructed, communal experience of reality (Cohen 1985); and as social networks of individuals unified by a common set of norms that are independent of location (Bradshaw 2008, p. 5). For the current study, we used the principles of symbolic interactionism to guide our understanding of how individuals with SMIs define their communities (Blumer 1986; Carter and Fuller 2016). Symbolic interactionism is founded on three main premises: (1) that human beings act according to the meaning they give to things (e.g., physical objects, ideas, institutions, situations around everyday life), (2) these meanings are derived from everyday interactions, and (3) these meanings are altered through an "interpretative process" influenced by these interactions (Blumer 1986, p. 2). Instead of focusing on how society and social institutions define and label interactions in the community for adults with SMIs, this framework prioritizes the "interpretation of subjective viewpoints and how individuals make sense of their world from their unique perspective" (Carter and Fuller 2016, p. 932). It has been argued that services that are more consumer-oriented and rooted in phenomenological concepts of community may be more successful at achieving the elusive "community integration" and improving quality of life (Pahwa et al. 2019). This study seeks to generate consumer data on their definitions and experience of community which will have direct relevance to efforts at defining and influencing community integration in mental health services.

Guided by symbolic interactionism, the specific aims of the present study are:

(a) To explore the ways in which individuals with SMIs define and experience their communities
(b) To develop a framework for illuminating how individuals with SMIs define their communities in the context of their lived experiences.

Methods

Study Design

Sampling

The sample was comprised of ninety racially/ethnically diverse participants with SMIs receiving community-based services in multiple counties in New York (n = 30), Los Angeles County, CA (n = 30), and Baltimore County, MD (n = 30). Participants were recruited via fliers posted in the reception areas of the agencies and through agency providers. They participated in an in-person or phone screening interview to assess for eligibility. Out of the 94 potential participants screened, 90 were interviewed. Participants met the following inclusion criteria: (i) English-speaking or American Sign Language if hearing impaired, (ii) diagnosed with SMIs (e.g., schizophrenia spectrum disorder, bipolar disorder and major depression), (iii) 18 years or older, and (iv) enrolled in mental health services for at least 6 months. Diagnostic information was self-reported and was also a requirement of their participation in their treatment programs. Exclusion criteria included (i) diagnosis of mental retardation or (ii) an identifiable neurological disorder.

Study Procedures

Ninety semi-structured qualitative interviews were conducted between November 2017 and September 2018. Interview questions explored individuals' perceptions and experiences with different self-defined communities. Study protocols were developed and refined with input from the Recovery-Oriented Care Collaborative (ROCC), a Los Angeles Practice-Based Research Network (PBRN). Institutional Review Boards at New York University, New York State Psychiatric Institute, University of Maryland, University of Southern California, University of California, Los Angeles, Los Angeles County Department of Mental Health and the internal committees of agencies approved the study protocols.

In-Depth Interviews Semi-structured qualitative interviews focused on questions about individuals' perceptions and experiences with different self-defined communities. The interviews began with a general question regarding their present life situation and followed up with questions like: "I'd like to ask you about your idea of a community" and "What does community mean to you?" Since the participants self-defined these concepts, the interviewers were able to explore how participants both constructed and described experiencing communities on their own without imposing pre-existing personal or theoretical constructs onto the interview process. Examples of specific prompts used to elicit participant's construction and meaning making behind their definitions were: "can you identify a community that you currently belong to" "what makes (name of a community) a community for you"? "how important is this sense of belonging."

After consenting, individuals participated in 60–180-min interviews in 1–2 sessions. Interviews took place in a private office at agency sites and were conducted by experienced interviewers with social work backgrounds (authors RP, MES, ELK, RJD and other social work masters and doctoral level research assistants). Participants received $30 for participation.

Demographic Interviews After completing the in-depth interview, interviewers collected survey data to obtain background information including age, gender, race/ethnicity, marital status, number of children, diagnosis, employment, and housing status.

Data Analysis

Interviews were audio-recorded, transcribed and checked for accuracy by the research team members. Consistent with constructivist grounded theory (Charmaz 2014), transcribed interviews were analyzed as data was being collected. ResearchTalk's "Sort and Sift, Think and Shift" methodology (Maietta 2006) was used for analysis. This methodology includes a flexible combination of diagramming, memoing, creating individual participant "episode profiles," and monitoring salient topics using a parsimonious set of codes grounded in careful review of the data. The code list for this study included a combination of descriptive, in-vivo, and process codes (Padgett 2016; Saldaña 2015). The analysis team was comprised of five trained qualitative analysts and co-authors on this manuscript (RP, MES, ELK, RJD, and AH). The current analysis focuses on codes related to two interview prompts: "What does community mean to you?" and "Which community or communities do you feel you belong to?".

During the initial coding process, all the analysts assessed the same eight transcripts using Dedoose (Dedoose Version 8.0.35 2008) to develop a codebook through regular discussions of memos and data to justify creation and meaning of the codes. Once consensus was reached, the interviews were divided so each interview was coded by a primary and secondary coder. Any coding discrepancies were discussed and resolved by consensus.

After initial coding, the team conducted focused and axial coding whereby codes that clustered around similar definitions and experiences of community were merged.

As we began theoretical coding, we identified two broad categories of codes related to community definitions: static codes and dynamic codes. Under static codes, communities were defined as something tangible and we categorized these under the *structural* aspects of community. Dynamic codes, on the other hand, included definitions centered around their communities as intangible constructs. We further divided these dynamic codes into *functional* and *experiential* aspects of the community, thereby leading to the Structural–Functional–Experiential (SFE) model of community. The authors (including the coders) regularly met throughout the data analysis process to discuss themes around these elements of community.

Rigor

We enhanced the rigor of the analytic process through multiple strategies (Creswell and Creswell 2017). Throughout the data collection process, the interviewers wrote reflection and documentation memos discussing their experiences of the interviews. We also documented key quotations and discussions by participants that related back to the study research questions. Research team members met regularly to discuss emerging topics across participant interviews. Throughout the analytic process, the five analysts (RP, MES, ELK, RJD, and AH) engaged in constant comparison of the data by reviewing transcripts to search for confirming or disconfirming information related to topics and categories that led to the development of an initial codebook and subsequent analysis.

Results

Participant Characteristics

Average age of the participants was 43 years (*SD* = 13.98). Fifty-nine percent (n = 53) identified as cisgender male, 40% (n = 36) as cisgender female and 1% (n = 1) as transgender female. Over 80% of the participants identified as a racial or ethnic minority. Approximately half of the participants had children and 18% either had a job or volunteered. All participants were enrolled in a variety of services that ranged in intensity and treatment focus. (Please refer to Table 1 for detailed demographic and clinical information.)

Table 1 Sociodemographic and clinical characteristics of participants (N = 90)

	N (%)	M (SD)
Age		43.10 (14.22)
Gender		
Cisgender male	37 (41.11)	
Cisgender female	52 (57.78)	
Transgender female	1 (1.11)	
Race		
Black/African–American	51 (56.67)	
White/European–American	15 (17.78)	
Latinx	13 (14.44)	
Multiracial	5 (5.56)	
Other	5 (5.56)	
Marital status		
Married	8 (8.89)	
Widowed	3 (3.33)	
Divorced	10 (11.11)	
Separated	4 (4.44)	
Never married	65 (72.22)	
Employment status		
Unemployed	74 (82.22)	
Employed	16 (17.78)	
Housing status		
Independent housing	42 (46.67)	
Provided by agency	18 (20.00)	
Other	30 (33.33)	
Any children		
No children	53 (58.89)	
At least 1 child	37 (41.11)	
Primary diagnosis*		
Schizophrenia	69 (79.31)	
Bipolar (I, II, NOS)	7 (8.05)	
Depression	7 (8.05)	
Other	4 (4.60)	

*N = 87

Defining Community

In response to the prompts noted above, participants shared their definitions of communities that included both tangible and intangible elements. We have described the broad definitions and specific elements of their definitions in Table 2. We have organized the definitions into three aspects of community: the *structural,* the *functional* and the *experiential*. The structural aspects of community include the tangible communities including people and places that the participants included in their definitions of their communities. Under the purview of people, their definitions included groups of people or collectives, family members, friends, individuals associated with their mental health service community, and people with whom they had hi-and-bye relationships. Hi-and-bye relationships included chance encounters (e.g., people on the bus) and transactional relationships (e.g., cashier in grocery store) in public places that created a "*friendly atmosphere*" where everyone supports each other, "*looks out*" for each other, and fosters a general sense of belonging. The places aspect of community included

Table 2 Defining communities (N = 90)

Definitions	N (%)[†]	Example quotations
Structural communities		
Community as people		
Collective/group	29 (32)	It's amazing that we can be—there can be so many of us, but we're all interdependent upon one another, interdependent it is just nature's way of letting us know that we're not alone
Family	15 (17)	When you get friends and family together and you associate with each other and do things within a community
Friends	15 (17)	A community I belong to is like, a positive environment, and hang around positive people and interacting with my peers
Hi and Bye relationships	13 (14)	I feel like I belong there. The people in the stores are really nice to me. The people in the neighborhood are really nice to me. When I'm going to get my coffee at different times of day, you see the same people regularly, going to get their coffee and their cigarettes, and you talk for a little while, exchange a little bit of words or a little conversation. The guy who makes the sandwiches, talk to him about whatever
Community as place		
Neighborhoods/location	60 (67)	A place I live and where I reside, um, uh, where I do a little bit of business
Cultural spaces like churches	13 (14)	I don't belong to a community in my neighborhood, except there's a church in the neighborhood that I frequently visit
MH services[††]	22 (24)	(An) example of a community, I guess it could be, like, like a community of people, like sorta like here at (name of the agency), like everybody here has a mental health issue, so I feel very a part of that 'cause I feel like no matter where I go inside of this building, everybody's gonna understand havin' a mental illness and, you know, what that means, and how to, how copin' with it can be difficult and all of that
Functional communities		
Socializing	29 (32)	Community means all the people you normally see on a regular basis, pretty much regularly, and how you interact, and I guess how you seem to get along or not get along
Helping	25 (28)	People helping one another and not doing it because they want something in return or feeling like I could trust this person. That's a community, you know? Seeing if somebody's in need they go and help or they you know, keep their city nice. They're there for each other to help each other
Receiving resources	23 (26)	Community means, uh, like you say, get out there and, um, associate with people, try to go to church, um, try to go to places where you can get the help, help from, and if you umm, start getting sick, like, off of drugs or you wanna go back that way, umm, and alcohols, they got a hotline you can call before you go make a mistake like that
Experiential communities		
Sharing struggles and experiences	22 (24)	Community is a bunch of people from different ethnicities and backgrounds that share the same common area; you know that um… where they live and they do everyday things such as going out to eat, going out on dates or you know school, jobs. And tum… they just, you know, interact with one another and try to make the best of what their community is
Finding safety	7 (8)	It means, you know, having people around, having a safe place to go to. Community for me would be my groups. My family is a community that is safe for me
Identifying	5 (6)	The gay community… I did a lot of volunteer work during high school and when I first came out, and so it was the gay community mainly, and um… women's rights when I had did it at like a women's shelter for like a couple of months and stuff like that. I've seen the shit that these women fucking had to deal with, and then I ended up later on, years later having to deal with the same situation but not as bad as most

[†]Frequencies and percentages are for information only. They do not signify weights or significance given to each element in the model

[††]Even though mental health services are represented under place, it was also represented as an intersection of people and place

neighborhoods and other physical spaces like mental health service settings, churches, stores, or community centers. In addition to these tangible elements, participants also defined their communities in terms of certain intangible elements that we call *functional* and *experiential*.

The *functional* elements represented experiences of communities that served a function like providing and receiving help, resources, or opportunities to socialize. The *experiential* elements included finding other people or places where they shared experiences, struggles and identities, and felt a sense of safety.

Consistent with participants' definitions, we clustered these conceptualizations under three broad intersecting categories comprising the proposed *Structural, Functional* and *Experiential* (SFE) model of community (see Fig. 1). This model is an overarching framework to organize the widespread elements identified by participants. While these specific elements of community were sometimes experienced singularly, they were often nested within each other, whereby tangible elements of community (structural) were associated with some intangible aspects of community (functional and/or experiential). The following section describes the intersection of the structural, functional and experiential categories of community, highlighting the elements that interact across categories. Participant quotations are provided to illustrate how these intersections were identified in the data.

SFE Model of Community: Combinations of Structural, Functional and Experiential Communities

Intersection of the Structural and Functional Communities

Functional communities were often layered onto the structural communities, whereby specific people or places served different functions (socializing, receiving and giving help and resources), which led to a positive sense of community. For example, a participant talked about community as "*a group of people living pretty much in the same area, [having] the same goals, helping each other, serving each other…different things, churches, shopping centers*."

Socializing and Structural Communities

Participants talked about community as a specific location where people get together to *socialize.* Socializing activities evoked positive and welcoming feelings, grounded in both specific places (like childhood neighborhoods) and specific people (like peers). For example, a participant talked about community in the context of their LGBT group where participants have shared experiences and "*attend this group to meet friends, talk about different topics and discussions, like the struggles of the LGBT community within itself and the small minorities within those divisions*."

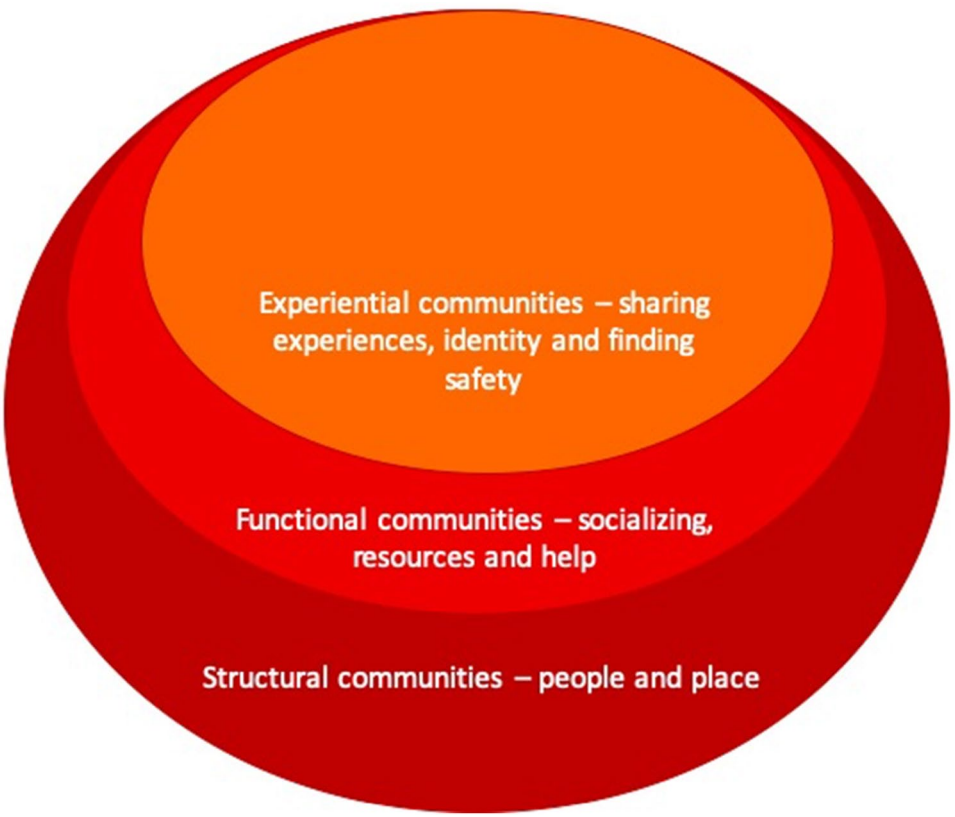

Fig. 1 SFE model of community: structural, functional and experiential aspects

Socializing implied being "*out there*" and interacting with people in a community (*hi-and-bye* relationships). Participants described their communities as going out for coffee, cigarettes, and regularly having conversations with others. The content of these exchanges seemed less important than the sense of connection. For example, as one participant described positive interactions, another described her living community as nice, quiet, and where people look out for each other.

Friends and family also were identified as communities of people with whom participants spent time and socialized. For example, a participant talked about community as composed of friends who helped each other out both emotionally and with resources: "*Going with my friend to help him. To me, that's the community, you know, positive people in your life to keep your activity positive*." Participants identified both past and current friends as their communities. For example, this participant talked about how he still thinks of his past friends as a part of his community even though they might not hangout as much as they used to: "*I have concerns for different kinds of people now than just people I had concern for when I was growing up. But we're still friends, though.*"

Some participants identified churches as spaces to socialize generally or to connect with specific individuals such as pastors or other community leaders for advice and guidance. For one participant, church served as a place to develop relationships in new communities through her dancing at church.

The mental health services community also came up frequently as a community, across multiple intersecting definitions of community. Participants highlighted the mental health community as a nexus of physical places and people that provided opportunities for socializing. For example, a participant talked about the importance of socializing via activities organized by their agency: "*Every Thursday, we go on an activity. Go to the movies, eat at nice restaurants, go up to the mall. I enjoy that.*"

Help intersecting With Structural Communities

Participants talked about *receiving and giving help* as a way to connect with their communities. One participant talked about a sense of selflessness associated with the idea of community as helping: "*People helping one another and not doing it because they want something in return or feeling like I could trust this person.*" Another participant talked about community as, "*…working and helping people and doing things like going to the soup kitchens and give it to some of the homeless people*."

Structural Communities and Resources

Participants identified *resources* (material or services) available in physical locations in their definition/identification of community and gave examples of how people in specific places come together for the common good, as described by a participant:

> In Santa Barbara with the mudslides, the community came together and helped the city clean up because they're part of the community. I saw on TV that a neighbor rescued another neighbor's miniature pony and kid...That's a community, you know? They're there for each other.

Friends were also identified as a primary community that provides resources and "*look[ed] out*" for each other. Several other participants described their connections within religious institutions, LGBTQ groups, and community centers as a means to obtain help and resources and to give back or "*pay it forward*." For instance, a participant stated:

> To me, that's the community…I'll see somebody asking me for some money, if I can afford to give it I will because that's to me paying it forward. It's just me giving from my heart from God because I'm trying to help God's people.

Other participants emphasized the tangible supports that they received through other community spaces like community centers and their mental health service agencies.

Intersecting Structural and Experiential Communities

The structural communities also had layers of experiential aspects of community including experiences like shared struggles, a sense of common identity, and finding safety. Participants experienced communities within the contexts of their experiences in different places and with different people, and described how these experiences felt to them.

Common Struggles and Identities Within Structural Communities

Participants described communities as people and places where they had access to opportunities for sharing common experiences, struggles and identities. These experiences provided a sense of purpose and belonging to a group of people striving for the same things. For example, a participant described how individuals who were homeless and living on Skid Row in L.A. represented a long-standing community for him due to the shared experience of homelessness. These experiences could be rooted in

common goals or a sense of connection with each other, as described by a participant: "*We may not listen to the same music or dress the same, but we have the same spirit or an ethereal, metaphysical community*." Another participant talked about how his music connects him to people and how these connections improved his well-being:

> I feel a part of everything… I mean, because me being a singer, everybody loves me, they want me next to them, around them… I said people really like music so that makes me feel good.

Some participants identified their mental health services community as their only community; their shared experiences in this space were key to their ability to connect to others. For example, a participant described the mental health community as their primary community, but called it a "*community of mis-casts doing their own thing."* Others identified mental health services and associated people as communities and people with whom they had shared experiences. For example, a participant shared that her mental health community was "*the only place that I can communicate with people and I feel like this is my family here 'cause these the only people I know*."

Feeling Safe

Participants also recognized feelings of safety as an important element in their experiences of their communities, which included a general sense of safety as well as specific instances and places where they felt safe or unsafe. Concerns about safety largely derived from the conditions of their current neighborhoods and their comparative safety in their previous neighborhoods. Participants identified neighborhood characteristics, such as the presence of drug dealers or presence of violence, as significant barriers to feeling comfortable in their communities. For example, this participant talked about his neighborhood and the drug dealers "*in the corner*" that concern him: "*These people, they're bad. They don't want to keep it up, you know, they're asking for rent and money and food. They're asking for contributions*."

Others talked about safe spaces in a more abstract form: "*I think community is a safe space for different people from different walks of life to come together and form like this trust. A community is a safe place for people.*" One participant talked about a lack of safety in terms of their psychological sense of not being accepted, whereas several others talked about safety in the context of finding acceptance. For example, this participant talked about community as a combination of safety and family: community is "*having a safe place to go to. Community for me would be my groups. My family is a community that is safe for me*."

Intersection of Structural, Functional and Experiential Communities

Most participants experienced community as a combination of structural, functional and experiential elements. For instance, participants related certain people or places with a sense of community because of the function they play in their lives (e.g., providing resources or opportunities for socializing) and the way these people/places and interactions made them feel (e.g., a sense of shared identity or safety). In that sense, these elements were nested within each other and each community definition mapped onto more than one element. For example, participants identified the shared struggles of having a mental illness and how these struggles contributed to sharing of help or resources that created a sense of community. For example, the following participant talked about community as existing within his mental health service agency, where mental health consumers shared experiences, a sense of belonging and a nonjudgemental atmosphere:

> I think community is like when there's people that know each other, that know what the process that they're going through, helping each other out instead of criticizing. You know, living life in harmony and peace. That's what I believe it would be. Like the community here at the [mental health] clinic, that's what I think it is, that everybody's a little different in the elements and the scenario but I think that's what that would be.

Another participant talked about their neighborhood as a place where they felt safe and had a sense of camaraderie: community is "*having friends… like what where I live at is like a Jewish community… It really is a nice community. And we talk and look out for each other—and it's quiet.*"

Other participants discussed various identity communities as integral to their community experiences. For example, one participant, talked about an LGBT community center as a place that served specific functions (resources, socializing and sharing common struggles):

> I definitely belong to the LGBT Center. They have 20 sub-based groups, every Wednesday, meaning like, if you're in your 20s, you can still attend this group to meet friends. We talk about different topics and discussions.

Another participant talked about a community center as their community that was "*peaceful*" and also provided socializing opportunities:

> In my neighborhood we had a community center that we go to…and we gathered there and we had fun, and

participate in activities. We had lunch there and it's like we get to know other people.

Lack of Community

In contrast to participants who focused on socializing as central to their definition of community, a small segment (n = 4) of the sample referred to a "*lack of community*" in their definition. For some participants, this may reflect their confusion about what community might encompass, as their initial responses to the prompts were, "*I don't know*," or "*What do you mean*?" Isolation or absence of community was a significant challenge for these participants:

> I have very few friends, so that community is limited too. It's usually just one-on-one with those types of people, so I don't do too much with groups outside. Usually just one-on-one with a friend or, you know, maybe one or two friends kind of thing.

For others, the absence of community was seen as comfortable or protective from future harm (e.g., rejection, traumatic loss). Other participants were very clear about not being a part of any community due to reasons like lack of resources ("*I'm not currently a part of any community. Not yet. 'Cause I don't have my own place*,") and stigma ("*Being right now that I have this mentally ill stigma on top of me, I don't feel that I'm a very progress [sic] member of society*.").

Discussion

Despite the existing research on the importance of community integration to facilitate and sustain recovery for individuals with SMIs, implementing and sustaining programs that facilitate integration are a critical challenge for community mental health agencies and consumers. Although prior research has identified some key domains of community for this population, our findings illustrate that individuals with SMIs define and experience their communities in more layered, complex, and multifaceted ways than is typically conceptualized by researchers or operationalized by providers and policymakers of community integration services. Our development of the structural–functional–experiential (SFE) model of community offers a framework that provides conceptual organization and guidance for clinicians, researchers, program developers, and other stakeholders regarding the complexity and variability of the expence of community for their consumers. Our SFE model is based on the voices and lived experience of consumers, which are essential to their recovery.

The SFE Model as a Framework

The broad and diffuse nature of definitions of community has created a great deal of confusion within the field for how to conceptually organize its multifaceted elements. The SFE model of community provides a nested framework which posits that *structural elements* of the community provide the tangible elements (i.e., places, spaces and people) that combine with the *functional* and/or *experiential* elements of community experiences (singularly or in tandem). These overarching structural elements are interrelated to the functional and experiential elements that identify aspects of their community experience. For example, structural elements like community centers, churches, and wellness centers are associated with a sense of community since they can provide a place for functional opportunities like socializing, help or resources. Additionally, structural elements are rooted in emotional experiences that go beyond the tangible and evoke emotions (*experiential elements*) such as a sense of belonging due to shared identities, struggles, or feelings of safety. However, for many individuals with SMIs, community represents combinations of the structural, functional and experiential elements rather than a singular component as is typically presented. For example, participants identified family (*structural*) as an important part of their community experience. They socialized with family and gave and received help and resources like money (*functional).* Sometimes family was referred to metaphorically to describe an ideal community or how individuals related to a group of people that were generally close and supportive regardless of kinship (*experiential*). Similarly, the mental health services community was identified as a structural community (where they spend their time and met providers and other peers) as well as a community where they got opportunities to socialize and get resources (*functional)* and where they felt safe and got a sense of shared experiences (*experiential).*

The SFE framework provides an overarching structure that encapsulates the experiences of individuals with SMIs. Previous and contemporaneous literature also support individual elements of the SFE model as important to the community experiences for individuals with SMIs. Similar to the participants in the current study, other studies (Bromley et al. 2013; Pahwa et al. 2020; Townley et al. 2013) have discussed communities for individuals with SMIs as places and people with whom they felt a sense of belonging, identity, shared struggles and safety, including mental health service communities (covered in more depth with this sample in Pahwa et al. in press). Bhattacharyya (2004) identified community in terms of solidarity and common values, social norms and attributes that could lead to a shared sense of identity. A common concern among providers is about the possible harms of individuals with SMI becoming siloed within mental health communities. Therefore, it

may be important to help participants find communities that are receptive to their mental health symptoms and embrace other aspects of their identities or experiences, which can be guided by their preferences. Townley (2015) noted that participants with SMIs talked about churches as safe havens but also as a way to find support for their mental illness. This is also consistent with other literature on the importance of church and spirituality, especially for African American participants (Armour et al. 2009; Pahwa et al. 2019).

For individuals with SMIs, community has been tied to interdependence (Blackshaw 2009) as well as help, resources and opportunities to form social connections that individuals derive from the people with whom they interact (Bromley et al. 2013; Pahwa et al. 2014; Wong and Solomon 2002). Critically, individuals' social networks are not restricted to individuals in their geographical proximity (Bhattacharyya 2004), but as the "networks of people tied together by solidarity, a shared identity and set of norms, that do not necessarily reside in a same place" (Bradshaw 2008, p. 5). Instead of focusing on singular elements of community in terms of geographical places, neighborhoods and spaces, or groups of people who interact with each other and have common interests, shared goals and a collective sense of identity, our results and the SFE framework indicate that these distinguishable elements of community overlap and are simultaneously experienced.

Limitations

Results of this study should be interpreted with several limitations in mind. While our findings are based on the heterogeneous experiences of individuals with SMIs living in three different geographical regions, they are all largely urban geographical contexts. Future studies should also include other contexts including community experiences of individuals living in rural areas and individuals not engaged in mental health services. In addition, data for the current study are from cross-sectional semi-structured interviews, which limits our ability to understand how these experiences may change as clients age or as they progress through treatment; these experiences should be the focus of future studies. Lastly, the majority of our participants primarily had psychotic disorders and future studies should explore whether there are important differences between those with primarily mood or psychotic symptoms.

Implications for Community Integration

Notwithstanding these limitations, the results of this study have important practice and research implications for the conceptualization and implementation of interventions related to community integration. Implementation of community integration programs have focused largely on the structural aspects of community with supported housing (Padgett et al. 2006; Wong et al. 2008) and community inclusion programs (Salzer and Baron 2006). These models presume that people actively living in the community will automatically form ties and feel a sense of belonging (Mancini et al. 2015) in these communities. However, this is not the case for all, as many individuals in community-based mental health services experience high rates of loneliness and networks that are mostly populated by service providers and other consumers of mental health services (Padgett et al. 2008; Pahwa and Kriegel 2018). However, it is important to note that participants did not always distinguish those in their mental health services communities from those in substance use or physical health communities (e.g., support groups for those with HIV). This suggests that these results also have implications for community with systems that coordinate or are integrated with mental health services, as community members may represent those from multiple systems.

The results of the present study suggest the need for community integration interventions that are flexible, personalized, multifaceted, start from an individual's own conceptualization of community, and build upon their existing communities, or at least their concepts of community. The SFE model of community provides an overarching organization of the factors comprising community, which, on one hand, can account for the complexity of the community experience and on the other hand, can streamline how clinicians and providers conceptualize and design community integration services. For example, based on the SFE framework we are currently developing an assessment that could be used to promote awareness and individualized goals to facilitate community integration for individuals with SMIs. The SFE framework is proving useful to these intervention development efforts.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

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