

HEALTH RISKS AMONG SPECIAL POPULATIONS IN THE CITY

Conservatives argue that the United States “won” the Cold War . . . But the economy that won this victory cannot house its own people and condemns a significant percentage of them to a life of poverty and struggle. If this is victory, it is hollow indeed.

Joel Blau

Something that might at first seem a superficial matter, a mere question of where one lives, can in some cases have a surprisingly deep effect on the shape and feel of the old person’s social world.

Arlie Russell Hochschild

A majority of Americans live in an age of instant access to everything and every place; the Internet, texting, tweeting, and facebooking make the world appear to be at our fingertips. In this “information society,” where communication technologies expand the capacity for exchange exponentially, we seem to be approximating a situation in which, as some media campaigns have suggested, there will soon be “no there, there.” But this world of immediate accessibility is illusory. Indeed, as the information highway gives us the capacity for a truly global village, a new version of the divided society is emerging, with inequalities as dramatic and debilitating as any that have existed in human history.

We have demonstrated throughout this book that place continues to matter for everyone. Despite the emergence of the spaceless realm in the information-based society, some groups remain very spatially dependent. In this chapter, we explore the special problems and needs of four groups, showing how spatial contexts interact with limited personal and social capital to constrain the opportunities and experiences of each group. We discuss some of the spatial challenges faced by the homeless, low-income racial and ethnic minorities, as well as the unique person-environment challenges confronted by those at the beginning and the end of the life cycle. Each of these groups represents a set of unique ecological actors who face special challenges living in the urban environment.

The first part of the chapter deals with the significance of space and place for the health of the socially disadvantaged. Overwhelming evidence suggests that the already health-compromising circumstances of personal poverty are further exacerbated by the fact that the very poor often find that they are unavoidably “in the wrong place at the wrong time.” Such is the story of the impoverished, predominantly African American residents of Village Creek. It is also the picture presented in research on homeless persons where the stressful circumstances of placelessness are clearly demonstrated (Fitzpatrick et al. 2007a; Fitzpatrick et al. 2009; LaGory et al. 2005).

The Homeless

As the economy has globalized, large sectors of the urban poor have become increasingly underemployed and the poorest have gotten even poorer. Since the financial collapse of Wall Street in 2008–09, an even greater marginalization of the poor has taken place. Stagnation and decline in the nation’s housing market, coupled with record levels of unemployment and underemployment have meant increasing numbers of urban poor risking homelessness. Among the most susceptible to these risks are the poor who suffer from some form of health problem—addictions, chronic physical health problems, or mental illness.

The spatial deprivation of homelessness represents an extreme form of poverty. It is an unhealthy state—an inhuman condition because we are

place-oriented by nature. The homeless can make no claims to the spaces they occupy. Homelessness leaves critical place-based needs such as privacy and minimal personal space, access to places for social interaction, and safe and defensible spaces unmet. While place matters, being without place matters to human beings. We spend our entire lives struggling to find “our place” in society, in history, and in the cosmic order; the link between place and identity is basic. It is not surprising, then, that when homeless persons are asked about their single most important possession, the majority list things connected directly with their identity—identification cards, official papers, or personal and family photographs—rather than more instrumental objects such as money, clothing, travel bags, or weapons (LaGory et al. 2005). In a personal world without territory, nothing becomes more critical or basic than establishing one’s place in society.

Risk and Hazard among the Homeless

The mixture of dangerous circumstances, psychologically debilitating experiences, and a high propensity for risk-taking behavior has dramatic health consequences for the homeless. These risks and hazards result in a significantly higher rate of infectious diseases, chronically debilitating illnesses, and criminal victimization than for the general population.

The hazards of living in public space’s interstices are many. Homeless environments are less predictable and controllable. Among the everyday hassles confronted by the homeless are problems with noise, privacy, overcrowding, theft, safety, and access to basic resources such as food, toilets, and clothing. Not only do the homeless live on the margins where space can be easily reclaimed by force or threat of force, but also the spaces they occupy tend to be non-residential in character, posing unique dangers to those in residence there. Living in these marginal spaces increases exposure to the hazards of weather, chemical and noise pollution, unsafe building materials, dilapidated structures, combustible materials, poor ventilation, vehicular and pedestrian traffic, and vermin. Indeed, the so-called “street homeless” are officially defined as residing in spaces not meant for human habitation, such as “streets, parks, alleys,

parking ramps, parts of the highway system, transportation depots and other parts of the transportation systems (e.g. subway tunnels, railway cars), all-night commercial establishments (e.g. movie theaters, laundromats, restaurants), abandoned buildings, squatter situations, building roofs or stairwells, chicken coops and other farm out-buildings, caves, campgrounds, vehicles and other similar places” (Burt 1992b:3).

Homeless people dwell in a socially predatory environment, where security and defense is a constant concern. Living in public spaces, even on the margin, exposes people to the risks of intrusion, creating a sense of defenselessness and insecurity. Those living on the street often compensate for this lack of security by adopting a military-like strategy in which individuals take shifts watching for intruders during sleeping hours. It is hard to feel at home when, during sleeping hours, circumstances are more like a battlefield than a home. Almost all homeless persons characterize the streets as dangerous, particularly at night (Fitzpatrick et al. 1993). Criminologists argue that the convergence in time and space of *suitable targets*, *motivated offenders*, and the *absence of capable guardians* increases the probability of predatory offenses such as robbery and assault (Cohen and Felson 1979). These three conditions are present on the street. Not surprisingly then, victimization rates are unusually high among the homeless (Fitzpatrick et al. 1993; Institute for the Prevention of Crime 2008; Kushel et al. 2002; Wachholz 2005; Wenzel et al. 2001).

In a 2005 study of homeless in Birmingham, Alabama, 17 percent of respondents said they had been robbed in the six months prior to being interviewed. Twenty-three percent of those victims had been mugged or beaten up during the robbery (LaGory et al. 2005). When robberies were excluded from victimization episodes, 12 percent said they had been attacked with a knife, and 51 percent said they were attacked with a gun. These rates of victimization are dramatically higher than those in the general population (LaGory et al. 2005). Additionally, there were ten times more rapes and nearly eight times more assaults among the homeless over those previous six months compared to the general population over the course of a year. A majority of homeless crime victims were victims of violent crimes. While some of the victimization rates could be attributable to poverty, research shows that rates of all types of

victimization are considerably higher among homeless than other low-income groups (Fitzpatrick et al. 1993; Institute for the Prevention of Crime 2008).

The risky circumstances of the homeless include exposure to violence, unsafe work conditions, marginal spaces, unpredictable environments, harmful chemicals and pollutants, and contagion. In addition, health risks are further exacerbated by the stress of a life situation which by its very nature frustrates basic physical, psychological, and social needs. These unsafe and stressful circumstances are sometimes accompanied by risk-taking behaviors, which may be an additional factor in the health of the homeless. Homelessness appears to be associated with risk-taking behaviors such as binge drinking, drug abuse, risky sexual practices, and weapons possession (Fitzpatrick et al. 2007a; Institute for the Prevention of Crime 2008; LaGory et al. 2005; Novac et al. 2006). Whatever the reasons, those engaging in risk-taking behavior further exacerbate their health-compromising circumstances.

Health among the Homeless

Placelessness is a fundamentally distressing circumstance—a chronic stressor. Much research demonstrates that severe stress can trigger significant mental health problems as well as genetic predispositions to certain physical disorders such as hypertension (Esch et al. 2002; Furumoto-Dawson et al. 2007; Krueger and Chang 2008). The physical circumstances of homelessness (crowding, dangerous sleeping sites, poor diets) also increase the chances of contracting chronic and infectious disorders. The high prevalence of disease is attributable to the spatial circumstances of the homeless lifestyle (constant forced walking, exposure to the elements, cramped sleeping arrangements, and poor hygiene).

National estimates suggest that approximately 20–25 percent of the homeless suffer from severe chronic mental illness (Substance Abuse and Mental Health Services Administration 2008), compared to approximately 6 percent of the U.S. general population. In many cases, mental illness is one component of a dual diagnosis of substance abuse and mental disorder. This co-morbidity indicates a complexity of health and

behavioral problems that makes treatment exceptionally difficult. Nevertheless, all major studies seem to agree that while mental illness is a significant problem for the homeless, the majority among this group does not have a severe mental health condition (Fitzpatrick and Myrskog 2008; Fitzpatrick et al. 2007a; LaGory et al. 2005; Snow and Anderson 1993; Wright et al. 1998).

Perhaps the most prevalent mental health problem faced by the homeless is depression. It is estimated that as many as 80 percent of the homeless population show symptoms of clinical depression (Fitzpatrick et al. 2007a; LaGory et al. 1990, 2005). Prevalence rates for depression are approximately seven times higher than among the domiciled population. Yet in most cases it would be inappropriate to designate this depressive symptomatology as mental illness. Indeed, it is more likely a normal psychological reaction to abnormal circumstances. Whatever its etiology (exogenous or endogenous), its prevalence suggests the level of suffering endemic to the condition of placelessness. Thirty-six percent of the homeless have had suicidal thoughts since becoming homeless, and approximately 45 percent of those persons have actually attempted suicide during their homelessness (Fitzpatrick et al. 2007a, 2007b; LaGory et al. 2005).

Racial and Ethnic Minorities

While some people are literally deprived of place, others find their place in society affected by an ecology largely out of their control. Segregation is a powerful force that reproduces inequalities over time by limiting access to the resources necessary to get by and to get ahead. Nearly 50 years after the civil rights movement, America remains a nation divided as it continues to confront disturbing inequities between Whites and non-Whites. At the heart of this division is a segregated society that perpetuates the barriers between rich and poor, White and non-White. Thus where we live in the metropolis is a function of the interrelationship between race and class, with residential location accentuating just how disparate some groups are. For example, we know that Blacks are more likely to get sick, stay sick longer, and die prematurely compared to

Whites (Do et al. 2008; Subramanian et al. 2005; Williams and Collins 2001). While other racial and ethnic minorities face similar disparities, empirical evidence suggests that health risks, mortality, perinatal health, disease and illness, and access to health care are of particular concern for African Americans (Bell et al. 2006; Collins and Williams 1999; Do et al. 2008; Kawachi and Berkman 2003; Lopez 2002). More than 40 years ago, the Kerner Commission warned that America was heading toward the creation of “two societies—one black, one White—separate and unequal” (U.S. National Advisory Commission on Civil Disorders 1968). This vision of the future has become a nightmarish reality for some as we arrive at the second decade in the new millennium.

As suggested in earlier parts of the book, health outcomes are a function of the complicated interrelationship between place, status, behavior, and social structure. While our intention has been to try to isolate this “place effect,” other aspects of the relationship need to be considered. In particular, this part of the chapter focuses on the interaction between status and place and its commanding role in determining negative health outcomes for at-risk populations such as low-income minorities. Indeed, the most compelling explanation for the severity of their experiences relative to other groups is their high concentration in areas undergoing the most severe economic and social decline—the inner cities. This concentration of poverty not only affects the social and economic health of America’s principal cities but also creates an underclass that slips further and further from the American dream. With more than 3,000 high-poverty neighborhoods in the United States containing more than 9 million residents, these places and their potential negative effects on residents’ physical and mental health are much too common an occurrence for such a wealthy nation as the United States.

Theories of the Underclass

Urban scholars have argued for some time now that an urban underclass, consisting largely of poor African Americans and other minority groups, has become a prominent feature of the American urban landscape (Jargowsky and Young 2005; Massey and Denton 1993; Sampson and

Wilson 2005; Wilson 1987, 1996). This group has generally been cut off from social and economic opportunities for growth and success. They are isolated within specific neighborhoods in the metropolitan area—powerless, marginalized, and unable to escape from poverty given their economic and educational deficiencies. How this underclass originated is of some debate, yet its role in helping shape the character of high-poverty ghetto areas seems clear. As low-income minorities have become increasingly concentrated in well-defined geographic areas, the level of poverty has been compounded and reinforced by a host of other problems, including high rates of crime, drug use, delinquency, teenage pregnancy, and welfare dependency. This cyclical process has further contributed to the demise of many urban neighborhoods, leaving their residents disconnected and underserved by the urban resource machine.

The truth of this characterization is confirmed in the neighborhoods bordering Village Creek. As we discussed earlier, many residents continue to struggle with the environmental threats (pollution and flooding) posed by the creek as well as the weakened economic and social structure of the neighborhoods they live in. From the eastern side of Birmingham originating in the Airport Hills neighborhood, Village Creek winds through or passes under 26 census tracts. Not all of these neighborhoods are exposed to the hazards and risks equally by the creek. Rather, three neighborhoods are exposed to flooding and its concomitant health risks. These places typify what contemporary urban scholars refer to as “underclass” neighborhoods that have become home to the new urban poor (Jargowsky 1997; Massey and Denton 1993; Wilson 1987, 1996). Jargowsky (1997), through a combination of fieldwork and review of prior community classifications (e.g. Wilson 1987), operationalizes the underclass (ghetto) neighborhood as predominantly Black with at least 40 percent of the total households living below the poverty level. Interestingly, all three of the census tracts identified as “problem tracts” regarding their exposure to Village Creek meet the criteria for an underclass/ghetto neighborhood according to the most recent Census estimates (U.S. Bureau of Census, 2000). In addition to their percentage of Black residents (98 percent) and percentage of households living below the poverty level (33 percent), these three Birmingham neighborhoods meet other

underclass criteria: median household income (\$15,338), the percentage of vacant housing units (14 percent), percentage of female-headed families with children (53 percent), and median home value (\$39,000).

Racial segregation is seen as crucial to both identifying and understanding the urban underclass. The process of segregation helps to explain why the urban underclass consists primarily of Blacks and Latinos—these are the two groups that most often have experienced increases in poverty and residential segregation simultaneously (Fong and Shibuya 2005; Massey and Denton 1993). Evidence seems to point to a recurring theme—in order to address the problem of poverty we must first address the problem of racial segregation.

Context and Health Differences

Based on earlier discussions, we know that racial and ethnic minorities are not randomly distributed in metropolitan areas. Rather, these groups are steered into a small number of neighborhoods characterized as high-risk places with poverty, crime, and illness occurring independently of any individual differences in socioeconomic status (Acevedo-Garcia 2001; Kawachi and Berkman 2003; LeClere et al. 1997). Several studies, while acknowledging that individual differences account for some of the variation in mortality between racial groups, demonstrate that community-level effects are important. Using data on a county in California, Haan and associates (Haan et al. 1987) found that both African Americans and Whites living in a high-poverty area experienced higher mortality rates than those living in non-poor areas. Whites in high-poverty areas experienced almost 50 percent higher mortality than Whites in non-poor areas, and when neighborhood poverty is controlled, the ethnic gap in mortality is reduced by nearly 25 percent. Their argument is that some ethnic groups experience higher mortality because of where they live rather than just because of their ethnicity. Places with low income and high concentrations of African Americans increase the likelihood of death for residents. Just as Jargowsky (1997) argues, these underclass neighborhoods are hazard zones where concentrated “deprivation can do irreparable harm.”

Often referred to as “sick” neighborhoods, these places become perfect storm centers where poverty, sickness, lack of access to grocery stores, high density, poor housing, commercial expansion (particularly liquor stores and fast-food restaurants) all converge to have a profound effect on these places and the health of their residents (Morland et al. 2002; Williams and Collins 2001). Recent studies pinpoint these risk environments, specifically examining the relationship between obesity and poverty in specific districts and neighborhoods (Drewnowski et al. 2009; Jeffery et al. 2006; Nelson et al. 2006; Wang et al. 2007). Some studies have established a link between the proximity/density of fast-food restaurants in poor, predominantly minority communities and health problems among residents, particularly but not exclusively among adolescents (Davis and Carpenter 2009; Kwate 2009; Lewis et al. 2005). As expected both racial (African American) and ethnic (Latino) groups are at risk and developmental consequences for youth continue to be well documented in these populations.

When illness and disease are examined the results are similar. The rates of morbidity mirror mortality, and while individual differences (health behavior, beliefs, attitudes, etc.) account for some of the gap existing between Whites and racial and ethnic minorities, community characteristics account for much of this difference. Though we have known for some time now that ecological factors play a significant role in determining physical and mental health, public health policy continues to ignore the power of the community in influencing healthy outcomes.

Health in the Hood

In 1900, the life expectancy at birth in the United States was 47.6 years for Whites and 33 years for non-Whites (most of whom were Black). By 2005, life expectancy for Whites increased to 78 years and 73 years for Blacks (Centers for Disease Control and Prevention 2008b). Yet while progress has been made in improving the health status of both races, Blacks continue to bear the burden of premature death, excessive illness, and disability. The differential quality of the residential environments of

Blacks and Whites clearly plays a critical role in shaping health and mortality (e.g. Jackson and Anderson 2000; Schulz et al. 2002).

While these problems are amplified among the Black population, they are not confined to Blacks. Deaths related to heart disease, cancer, and diabetes, as well as infant mortality tend to be higher among Hispanics, Cubans, Native Americans, and even some subgroups of Asian and Pacific Islanders (Acevedo-Garcia 2001; National Association of Community Health Centers 2009; U.S. Department of Health and Human Services 2009a). Additionally, Hispanics and Latinos face unique health challenges, with Latinos' rates for homicide, AIDS infection, and sexually transmitted infections (STIs) increasing, while drug and alcohol use continues to climb, and in some cases, outdistance that among their Black counterparts.

By paying more attention to the local geography and less to individual population differences, traditional explanations give way to more innovative ones. For example, Geronimus (1992) proposed a "weathering hypothesis" as a possible explanation for patterns of high morbidity and infant mortality among Blacks. Focusing on the hostility of the environment within which people live and work, she suggests that as exposure to environmental assaults and deficits increases with age, there is a worsening health status. A similar finding emerges in a recent study on the ethnic and socioeconomic factors that contribute to risk in cardiovascular heart disease (Winkelby et al. 1998). The study finds significant differences in health risks (blood pressure, smoking, etc.) between Whites and racial/ethnic minorities, particularly Mexican Americans and African Americans. The authors argue for exploring alternative causal pathways and suggest that different life experiences as well as economic, time, and most important, residential constraints may be competing with healthy behaviors to further increase the risk of heart disease among minorities.

The Ghetto Resident's Dilemma

Is it possible for an isolated subculture residing in a high-risk environment to establish and maintain healthy beliefs and lifestyles inconsistent with its surroundings? The thrust of our argument up to this point would

likely be a resounding no! Chapter 4's discussion of health theories provides a strong theoretical argument for why healthy attitudes and lifestyles are difficult to develop in the face of challenging ecological circumstances. The ghetto suffers from a lethal combination of ecological factors that often promote unhealthy attitudes, lifestyles, and risks, with little protection to circumvent negative health outcomes. Several ecological factors play a significant role in influencing the health and well-being of residents, by constraining residents' choices, limiting their access to health care services, creating unnecessary risks, and nurturing beliefs and attitudes that exacerbate an already desperate situation. The high-poverty ghetto's weakened institutional structures, high degree of segregation, absence of weak ties, limited social support and social capital, and lack of territorial functioning result in concentrated risks and hazards that Andrulis (1997) refers to as the "urban health penalty." The communities suffering most from this penalty are those isolated from the mainstream economy and segregated by race, age, and social class. This penalty only intensifies as urban hospitals continue to close, as urban minority physicians remain in short supply, and as the delivery of medical services remains unresponsive to the needs of people unable to afford health care.

Recognizing the significant interplay of environmental, social, and economic factors is critical to developing strategies that can improve the quality of life and the life chances of those living in disadvantaged neighborhoods. Any serious health reform effort must take into account the multitude of ecological forces and social problems that afflict certain at-risk communities. This "paralysis of place" certainly can be overcome, but not without comprehensive place-based programs that address the multidimensional needs of communities, while at the same time addressing the special needs of the populations that dwell within them.

Needs and Health Risks of the Young and Old

While place matters, its impact on the everyday life of residents depends on a complex interweave of personal and environmental circumstances and events. Place is personal, which is why place-related effects tend to

be modest yet persistent. Age is a particularly salient factor in the experience of place. Place of residence has less relevance for some age groups than others, precisely because people of certain ages tend to occupy wider activity spaces (Campbell and Lee 1992) and to participate in a greater variety of what Feld (1981) calls “ecological foci.” The two ends of the age structure—youths and elders—share important similarities as ecological actors. The local action space is often more constricted at these two stages of life because of mobility limitations. Due to the limited mobility of the young, the mental maps of children are especially striking in terms of their narrowly constructed bounds (Garbarino et al. 1992; LaGory and Pipkin 1981). The “ignorance surfaces” in the mental maps of elders are also notable, and are the result of reduced mobility, which accompanies old age. The places elders occupy are deeply embedded with memories, and hence, reliving past experiences with a place may intensify environmental experiences. Place experience in the form of reading about other places, or hearing about them through storytelling or conversation may be an especially important mode of environmental experience for both children and elders. Home and neighborhood are critical sources of experience and well-being for everyone, but for those at the beginning and end of the life cycle they retain special significance.

Youth at Risk

In a comprehensive review of research on neighborhood poverty, Brooks-Gunn and associates (1997) note the important role played by neighborhood environments in shaping child and adolescent development. Since that review, a number of studies have further articulated the place–development relationship (Drukker et al. 2003; Evans 2004; Fauth et al. 2007; Leventhal and Brooks-Gunn 2000; Rankin and Quane 2002; Sampson et al. 2008; Shonkoff and Phillips 2000). Despite the mounting evidence that place shapes developmental outcomes, little has been done to modify the harmful environmental circumstances present in America’s cities, placing millions of youths at risk. Children living in high-poverty ghettos are confronted with almost impossible odds in successfully maturing into adulthood. All the problems of urban,

post-industrial society are localized in these disadvantaged neighborhoods, and so its children are exposed to the hazards of the drug epidemic, rising violent crime, an increase in sexually transmitted diseases, a crumbling infrastructure, schools resembling jails, and vacant lots serving as dumping grounds.

Some two decades ago, in the early 1990s, it was estimated that roughly one in four children in the United States were at risk for some negative outcome (dropping out of high school, drug and alcohol abuse, violent victimization, teenage pregnancy, etc.) (Dryfoos 1990; Millstein et al. 1992). While there have been some dramatic improvements in specific risks over the last two decades, there continues to be overwhelming evidence that the greatest risks faced by youths occur to those living in America's disadvantaged urban neighborhoods (Mather and Adams 2006; U.S. Bureau of the Census 2007; Wolfe et al. 2006). The portrait of at-risk youth that follows describes circumstances heavily concentrated in the core urban areas of the United States.

(1) Youth at risk are more likely to be living at or below the poverty level

Poverty and community disorganization have grave consequences for the young. In 2006, 17 percent of American youth lived at or below the poverty line (U.S. Bureau of the Census 2007). While a majority of poverty-stricken children are White, minority children are much more likely to live in poverty, with 33 percent of Black children and 27 percent of Hispanic children living in poverty compared to 10 percent of White, non-Hispanic children (Federal Interagency Forum on Child and Family Statistics 2008). These children, living in poor families, often with a single parent, are at significant risk for experiencing difficulty in school, which in turn has implications for their adult futures (Mather and Adams 2006).

Poverty affects children's mental and physical health. Because poor children are likely to live in disadvantaged neighborhoods they are exposed to significant physical hazards as well as multiple stressors. Residence in such places increases their chances of exposure to toxic waste, substandard housing, air and noise pollution, as well as deviant

and violent circumstances. These risks and hazards promote illness and disease as well as great psychological uncertainty at a very crucial period in a child's development (Beyers et al. 2001; Evans 2004; O'Campo et al. 2000; Rabito et al. 2003; Wolfe et al. 2006).

(2) Youth at risk are more likely to be without a home

"Placeless" youth face significant challenges. While estimates vary, it is believed that over 1.6 million children and adolescents are homeless (National Center on Family Homelessness 2009; National Coalition for the Homeless 2008). Whether in a shelter or on the street, homeless circumstances are severe and long periods without a home promote a variety of health problems, including increased infections and poor nutrition, distress and anxiety, injuries, and exposure to violence (Health Resources and Services Administration 2001; National Coalition for the Homeless 2008).

(3) Youth at risk are more likely to be abused, neglected, abandoned, or orphaned

In 2006, over 3 million cases of child abuse were reported and, of those, more than 55 percent were substantiated, making for a prevalence rate of 12 per 1,000 children (Federal Interagency Forum on Child and Family Statistics 2008). Forty-nine percent of the maltreatment was the result of neglect, 29 percent physical abuse, 16 percent sexual abuse, and 6 percent emotional abuse. The majority of abused and neglected children live in low-income, principal-city communities where services are overburdened and often inadequate. The impoverishment of these neighborhoods makes effective responses to such abuse unlikely, since poverty burdens families and individuals with significant personal problems, eroding the social capital necessary to promote a blanket of protection (Wolfe et al. 2006).

In addition, empirical evidence suggests that the short- and long-term implications of abuse and neglect are significant. A host of problems including mental health, developmental, sexual, cognitive, and social disorders are associated with child abuse and neglect (e.g. Rankin and

Quane 2002; Repetti et al. 2002; Shinn et al. 2008). A perfect example is the experience of violence. Violent behavior appears to be transmitted from one generation to the next—resulting in a persistent sense of hopelessness and despair that intensifies the problems faced by families and communities struggling to break out of its cycle (Coid et al. 2001; Wolfe et al. 2006).

(4) Youth at risk are more likely to be exposed to drug and alcohol at an early age or, in some cases, in utero

Children are at risk sometimes before being born, and this circumstance is exacerbated in low-income, minority, principal-city communities in the United States. Poverty predicts many negative birth-related outcomes. Whether because of poor nutrition, inadequate prenatal care, smoking, drinking, or drug abuse, poor women are at risk of having more complications during pregnancy and higher rates of infant mortality (Hynes and Lopez 2009; Sims and Rainge 2002).

Smoking and drug and alcohol use among youths remain an important risk factor (Johnston et al. 2003; Federal Interagency Forum on Child and Family Statistics 2008). While long-term trends indicate some decline in drug and alcohol use among teenagers, in 2007, 26 percent of twelfth graders, 22 percent of tenth graders, and 10 percent of eighth graders reported binge drinking (having at least five drinks in a row) in the previous two weeks. Similarly, illicit drug use among teenagers declined in the last decade, but still remained high, with nearly 20 percent reporting having smoked marijuana and 14 percent sniffing glue in the last 30 days prior to the survey (Adlaf et al. 2003; Centers for Disease Control and Prevention 2008c). While estimates of drug use by location among youths are difficult to obtain, the strong relationship between drug use and poverty remains clear, and urban youths are at high risk of exposure to the drug culture (Fauth et al. 2007; Leventhal and Brooks-Gunn 2000). Ecological theories of health (see Chapter 3) further suggest that the risks of exposure to health-compromising circumstances by urban, poor youth will be exacerbated by neighborhood disadvantage, limited collective efficacy, and neighborhood disorder.

(5) Youth at risk are more likely to die while young or give birth while still a teenager

Poverty is often linked to early childbearing. Nearly one-half of children under six living in poverty have mothers who gave birth as a teenager, while only 17 percent of those above the poverty line have mothers who gave birth during their teen years (Centers for Disease Control and Prevention 2002). These children face a double jeopardy—exposure to poverty and a mother lacking the maturity and knowledge to be a good parent. That combination, commonly found among poor, urban Blacks, can have deadly consequences for the child.

While infant mortality in the United States has shown some decline in the last five years, the gap between Whites and Blacks remains significant. Blacks still have an infant mortality rate twice as high as Whites (Sims et al. 2007). The problems of the very young are compounded by health complications related to the circumstances of poverty, the hazards of urban living, and inadequate access to medical care (Centers for Disease Control and Prevention 2005; Fauth et al. 2007; Geronimus 2000). In addition to infant mortality risks, there are significant risks associated with low birth weight or premature delivery (Bauman et al. 2006; Bell et al. 2006; Hoyert et al. 2001; Reichman et al. 2009; Sims et al. 2007). Detrimental health and developmental effects are higher among poor children; low-birth-weight babies are more likely to suffer from disabilities such as asthma, cerebral palsy, mental retardation, blindness, hearing impairment, language dysfunction, and behavioral problems such as attention deficit hyperactivity disorder and oppositional defiance disorder (Almond et al. 2005; Brooks et al. 2001; Case et al. 2005; Costello-Wilson et al. 2005; Hack et al. 2005; Matte et al. 2001; Richards et al. 2001). Research continues to demonstrate how characteristics of inner city neighborhoods, ranging from outdoor air pollution to indoor contaminants, play a role in predicting such detrimental health outcomes for the urban young.

(6) Youth at risk are more likely to be exposed to sexually transmitted infections

While the percentage of 9th–12th graders having intercourse declined in the decade since 2000, still more than a third (34 percent) of young

women become pregnant at least once before reaching the age of 20 (Henshaw 2003). Boys report having more sexual contact, and at an earlier age than girls; rates of early entry into sexual intercourse are highest among low-income, minority youths. In addition, more than one-third of teens that are sexually active are having unprotected sex; unprotected sex has significant, sometimes deadly consequences for these youth.

One in four sexually active teenagers contracts an STI each year, with prevalence rates continuing to increase since the end of World War II (Kaiser Family Foundation 2005). Sexual contact and infection is highly correlated with socioeconomic status, race, gender, and age of adolescents, and AIDS has become the fastest-growing cause of death among adolescents and adults. Experts project that in the next 5 to 10 years, AIDS will be the leading cause of death among men of ages 25–44. Those youths at greatest risk of contracting the AIDS virus are runaways, prostitutes, and intravenous drug users. All of these groups tend to be concentrated in low-income, deteriorating neighborhoods of the central city, further promoting the circumstances for a subculture of health risk-taking behaviors in such areas. Once again, there is double jeopardy—those experiencing the most health problems live in the least healthy environments, where there is limited access to medical care (Cockerham 2007; Wolfe et al. 2006). In addition, these environments for socialization and development produce a context of hopelessness and helplessness that results in negative health behaviors.

(7) Youth at risk are more likely to be a witness or a victim of violence

The physical and psychological costs of violence exposure are considerable, particularly for children and adolescents. While violent crime rates among adults show signs of decreasing, juvenile crime and victimization continue to grow, approaching epidemic proportions. In 2005, youth aged 12–19 were twice as likely as adults to be victims of violent crimes (Baum 2005; Beyers et al. 2001). Likewise, the offending rate for youths between the ages of 12 and 17 reached a high of 52 crimes per 1,000 in the early 1990s. Since then the offending rates have declined, yet crime

continues to be significant among at-risk adolescents, particularly low-income, minority urban youths.

In addition to more obvious forms of exposure such as victimization, young persons are increasingly exposed to violence as witnesses in their homes, schools, and communities. In a 2008 national survey of exposure to violence, 60 percent of youth reported being exposed to some form of violence in the past year—as either a victim or a witness (Finkelhor et al. 2009; Guterman et al. 2002). In a recent survey of students aged 12–18, nearly 1.7 million reported being a victim of a non-fatal crime in school (Dinkes et al. 2009). Clearly exposure to crime in a variety of social contexts is a significant problem for youth—particularly older adolescents.

In an inner-city Birmingham, Alabama study that included the three high-risk Village Creek communities, 43 percent of youths interviewed said they had seen someone being killed by another person (Fitzpatrick and Boldizar 1993). Children growing up amidst this prolonged daily violence are at risk for serious developmental and psychological harm. A growing body of research shows that chronic exposure to violence increases susceptibility to a wide range of developmental and mental health problems, particularly among adolescents (Buka et al. 2001; Fitzpatrick 1997; Fitzpatrick and Boldizar 1993; Osofsky et al. 1993; Ozer et al. 2004; Richters and Martinez 1993; Salzinger et al. 2006).

(8) Youth at risk are more likely to experience mental health problems

An estimated 15–20 percent of American children suffer from some mental or emotional disorder (Melynck et al. 2003a). In addition, there is a critical need for mental health services to be delivered to young persons, particularly those living in high-poverty ghettos where services are either inadequate or non-existent (Andrulis 1997; Xue et al. 2005). Depression and anxiety disorders are high among young persons; between 15 percent and 20 percent of school-age children and adolescents suffer from one or more mental health problems, with only a small proportion of those receiving treatment for their illness (Garber and McCauley 2002; Kessler and Wallers 1998; Melynck et al. 2003b).

Experts argue that the rising rates of teenage homicide and suicide are a cruel outcome of overwhelming hopelessness, helplessness, and anger (Centers for Disease Control and Prevention 2006). These feelings of despair are amplified in the urban setting where schools are run-down, churches lock their doors at night, stores have moved out of the neighborhood, vacant lots and empty buildings outnumber playgrounds and occupied housing, and fear and distrust permeate everyday life. In the United States, nearly 17 percent of middle/high school students reported thinking about suicide in 2005; and nearly half of those had attempted suicide at least once in the past year (Centers for Disease Control and Prevention 2006). While suicide has declined in the adult population over the last several decades, it remains the third leading cause of death among youth aged 15–24 (Fitzpatrick et al. 2008). These numbers are staggering and deliver a harsh message that the risks associated with adolescence and young adulthood are high, and even higher in certain locations.

(9) Youth at risk are more likely to have difficulty in school and drop out

Poverty severely diminishes a child's ability to learn, his or her overall academic success, and the likelihood of graduation from high school. Family income is one of the strongest predictors of school performance; children from low-income families are five times more likely to drop out of school than children in upper-income families (Mather and Adams 2006).

As expected, this "education effect" is much worse in places where school systems are poor, facilities are run down, deviant subcultures concentrate, and education plays second fiddle to the higher-profile problems of crime, homelessness, and economic decline. While there is some controversy in its calculation and reporting, the national status dropout rate was recently reported to be nearly 10 percent (Laird et al. 2007). This rate measures the percentage of individuals not enrolled in high school and who do not have a high school credential, irrespective of when they dropped out. The measure provides an indicator of the proportion of young people who lack a basic high school education and this average

tends to be much higher in urban schools, particularly low-income, predominantly minority schools. Researchers have found that in one-quarter of all poor urban high schools, the dropout rate was 50 percent or higher (Braddock and McPartland 1992). The differences between these poor schools and more affluent ones, however, go well beyond dropout rates. For example, only one-half of graduating seniors in the United States attend college, and fewer than 25 percent receive a four-year degree. The majority of students, particularly low-income minorities, are faced with the challenges of finding work after graduating in a context where local jobs do not often match the skills of those completing school. Thus, high school graduates in disadvantaged neighborhoods are sometimes left to flounder, perpetuating the culture of hopelessness.

(10) Youth at risk are more likely to become an adult who is under- or unemployed

Youths from low-income families, particularly Black and Hispanic youth, are more likely to be neither enrolled in school nor working than White, non-Hispanic youth (Federal Interagency Forum on Child and Family Statistics 2009). Rates of unemployment for high school graduates are high, and in some cases exceed 30 percent (Haggstrom et al. 1991). Rates of inactivity (youths unemployed, not in military service, not attending college) provide further evidence of the growing “placement” problem among at-risk youth. Two years after graduation, the proportion of inactive youth often climbs; youth aged 18–19 (14 percent) are more than three times as likely to be detached from both work and school compared to youth aged 16–17 (4 percent) (Federal Interagency Forum on Child and Family Statistics 2009). What makes the transition from school to work so difficult is the lack of comprehensive job-related programs geared specifically to address the needs of inner-city, low-income minority youths. While unskilled employment is available, it is often part-time, with few or no benefits (Brewer 2004).

The word “epidemic” is often used to describe many of the contemporary problems facing young persons in high-poverty neighborhoods. The large number of single-parent families concentrated in disadvantaged

neighborhoods, along with the social disorder and limited collective efficacy found in some of these places, provide the necessary circumstances for the “contagion” to spread. Clearly, the number of risks and hazards confronting urban youth in such neighborhoods is considerable, particularly given their developmental capacity to cope with stressful circumstances. As a result of their limited mobility, immaturity, and dependency on others, these youthful ecological actors are often at the mercy of their surroundings and circumstances.

Elders at Risk: Physical and Mental Health Aspects of Aging

Just as youths are particularly sensitive to environmental factors, so are the elderly. While the majority of persons over 65 are healthy, significant physiological changes accompany the aging process, and in some cases affect everyday activity and transform place experiences. Such changes place elders at greater risk for certain environmentally related health challenges. For example, people at age 75 typically have 92 percent of the brain weight they had in their 30s, 84 percent of former basal metabolism, 70 percent of kidney filtration rate, and 43 percent of maximum breathing capacity (Kart 1990). Gerontologists suggest that changes in the skin, skeletomuscular, neurosensory, and cardiopulmonary systems associated with aging have the possibility of directly affecting elders as ecological actors (Satariano 2006). Mobility is sometimes reduced by neurosensory changes, loss of muscle power, osteoporosis, arthritis and rheumatism, and chronic muscular and joint pain (Roubenoff and Hughes 2000; Sharma et al. 2003; Sternfeld et al. 2002).

While many of these physiological changes are observable, others associated with aging are less so. Most notable in this less visible category of health declines are those related to the individual’s ability to achieve physical equilibrium (homeostasis). As people age, their ability to “get back to normal” after stressful events is reduced (Brunner 2000). Various systems and organs operate at reduced capacity. Blood pressure and heart rates take longer to return to pre-stress levels. The immune system is less able to protect persons from contagious diseases.

Old age, then, is not for the faint of heart. It can take a toll on mental as well as physical health. A range of stressful, age-related experiences are presumed to interfere with some people's ability to age successfully (Aldwin and Gilmer 2004; Aldwin et al. 2006; Chen and Wilmoth 2004; LaGory and Fitzpatrick 1992; Moos et al. 2005). These can include increases in age-connected stressful events or life circumstances such as the loss of friends or spouse, hospitalization, relocation, retirement, reduced income, chronic pain, or declining health. But they may also be due to changing physical and social environments such as a declining neighborhood, an aging house, poor access to transportation, or reductions in social support because of overtaxed social support systems or the loss of sources of support through death or illness.

Those caring for elders carry a heavy burden, too. This burden increases the likelihood of depression among caregivers, which in turn produces a "depressing" environment within the household (Ferrell and Mazanec 2009; Kurtz et al. 2005; Matthews et al. 2003; Whitbourne 2008). Events and circumstances associated with aging produce higher rates of depression in persons beyond retirement age (Aldwin et al. 2006; Karp and Reynolds 2009; Zarit et al. 2004). Indeed, of the non-organic mental disorders such as anxiety, paranoia, schizophrenia, and depression, depression is the most likely to have its onset in later life.

Besides depression, various forms of dementia are associated with aging. While a relatively small number of elderly exhibit any symptoms of dementia, currently over 5 million persons have Alzheimer's disease (Alzheimer's Association 2009; Esch et al. 2002), the most common cause of dementia among older persons. The disease develops gradually over an extended period of time with the duration of noticeable symptoms usually occurring within four to eight years (Administration on Aging 1998). Early symptoms include forgetfulness and some difficulty negotiating unfamiliar spaces, but as the disease progresses the individual becomes increasingly dependent on others for even the most basic needs.

While the majority of elders are independent and competent, some gerontologists have argued that they have a higher probability of becoming environmentally sensitive or docile (Balfour and Kaplan 2002;

Kawachi and Berkman 2003; Lawton and Simon 1968; Satariano 2006). They suggest that the reduced physical and cognitive competence associated with aging causes some elders to become more vulnerable to environmental factors. Coinciding with this increased sensitivity is a reduced ability and interest in manipulating and changing their environments. With age, the threshold of place awareness shrinks, and the potential for being more vulnerable to negative aspects of place grows. Spatial imprisonment puts the elderly at a disadvantage relative to other residents in communities where the range of personal support networks and social capital often extends beyond localized neighborhoods (Berkman and Glass 2000; Satariano 2006; Wellman 1979). The reduced mobility of some older people, perhaps because of losing the ability to drive, means that the aged are more likely to rely on neighborhood services and neighbors to support their needs, while the majority of metropolitan residents reach far from home to meet the needs of everyday life.

Lawton and Nahemow's (1973) theory of "environmental press" suggests the effect that environmental forces may have on the aged. In their thesis, person-environment relations are a function of the environment's capacity to challenge the individual (its "press" level), as well as the individual's ability to deal with these challenges ("competence"). Physical and mental health, sensorimotor functioning, cognitive skills, and personality factors such as mastery and hardiness can affect individual competence. Competence in dealing with the environment is often discussed in terms of the activities of daily living and the instrumental activities of daily living, which are all affected by the aforementioned factors. Can the person get by on his or her own, and what will the cost of limits to this independent living be to the person's general well-being? Is mobility impaired, and by how much? Can the person be independent physically? Can he or she take care of personal finances and access needed services? Approximately 20 percent of persons 65 and over have some limitation in their daily activities. By age 85, nearly half of all elderly have some impairment (Soldo and Longino 1988). Levels of impairment vary by income. Among men over 70 years of age, poor men are 1.8 times more likely to have some impairment, and poor women are more than 1.5 times more likely to be impaired (National Center for Health Statistics 1998).

Of course the individual's ability to live out a life in a given place also depends on the qualities of the local environment itself. The so-called environmental press level is gauged by how behaviorally demanding the environment is to residents. Are there significant hazards present that challenge the physical and mental health of the person? Is the environment dangerous in the sense that it has high levels of noise or chemical pollutants? What are the levels of local crime? How far away are the resources and services that the person needs in order to get by on a daily basis? Is the home and neighborhood physically deteriorating so that mobility may be constrained? Is transportation readily available? Are sidewalks and streets congested? All these questions concerning the state of the person and the environment relate to factors that determine the individual's ability to adapt to their environmental circumstances.

Space constricts with age as role loss, reduced income, decreased physical and mental competence, and increased fear take place. As people age, the distance traveled to get needed services and resources shrinks (Carp 1976; Ward 1984). Hence, for many elderly people, home and neighborhood become even more meaningful and consequential with time. Such places are often imbued with rich memories, since many people age in place. Indeed, the likelihood of a person moving within a five-year period declines significantly after the age of 30, and those least likely to move are over 55 years of age, a trend particularly accentuated for African Americans (Atchley 1991). Both of these consequences of aging, increased environmental sensitivity and constricted action space, suggest that elders are more likely to be at risk from the hazards present in their residential environments. Place means more for them, and as such, an ecological view of aging is most appropriate (Kawachi and Berkman 2003; Satariano 2006; Smedley and Syme 2000).

Neighborhood as a Healthy Place for Aging—Hazards and Risks

As their action space constricts with age, inertia takes on greater significance. Home and neighborhood matter more, particularly for those with limited spatial options. People age in place, and these places also age and

sometimes deteriorate. What are the hazards and risks affecting homes and neighborhoods as contexts for healthy aging?

Places like Village Creek contain physical, psychological, and social hazards for the elderly. Housing in such areas tends to suffer from age and deterioration, and these factors may be exaggerated for older, frail elderly (Iwarsson 2005; Oswald et al. 2007). Reschovsky and Newman (1991) have demonstrated a strong correlation between age, home maintenance, and housing quality. These hazards extend into the larger residential space of the neighborhood. High-poverty areas have a significant concentration of aging, dilapidated structures—poorly maintained residences, crumbling sidewalks, vacant buildings, etc. They also have higher densities of older persons than is typical for the metropolitan area (Fitzpatrick and Logan 1985; LaGory et al. 1980, 1985). Village Creek's high-poverty tracts are home to nearly 34 percent more elderly than the average tract in the Birmingham Metropolitan Area. Additionally, these high-poverty tracts have nearly 14 percent of their housing units vacant compared with only 9 percent in the Birmingham Metropolitan Area. When focusing specifically on households with persons aged over 65, 43 percent of these households in the Village Creek area have no car available to them, a figure nearly twice as high as that for the average elderly household in the metropolitan area (U.S. Bureau of Census 2000).

Age density also affects the character of a neighborhood. In such places, people deal with the consequences not only of their own aging, but also that of the neighbors who surround them. High age densities may create a local culture of vulnerability and an inability to respond to the changing circumstances in the neighborhood. The effects of age segregation can be further exacerbated by the fact that neighborhoods with a high concentration of older persons (both in central cities and in older, inner-ring suburbs) are also typically in places with higher levels of poverty, aging buildings, and larger numbers of unattached persons (Fitzpatrick and Logan 1985; LaGory et al. 1980). In central cities, these areas of concentrated aging also contain high concentrations of minorities, generally fitting the characterization of a ghetto (Jargowsky 1997). Thus, people find themselves addressing their own potentially stressful personal issues as well as the larger stressful context.

The concentration of hazard present in high-minority, high-poverty ghetto areas has already been explored in Chapters 3 and 5. Such areas tend to have high levels of violence, weak political ties, low territorial functioning, high degrees of transience, high vacancy rates, and extremely weak economies. Services are uniformly inferior to those available in other parts of the metropolis. Levels of fear are predictably higher, as are the stressors associated with daily living in such areas (Ward et al. 1986). These areas are “risk spaces.” Environmental forces in these risk spaces are stressful for all, but even more so for the elderly. As the docility hypothesis suggests, the elderly have a significantly higher risk of chronic degenerative diseases and cognitive impairments, making them more vulnerable to factors in the local environment (Lang et al. 2009). That vulnerability to environmental hazards connected with residence in disadvantaged neighborhoods is further intensified by elders’ tendency to age in place.

It is no surprise, then, that research finds great differences in the environment for aging in central cities versus that of suburban and rural communities (LaGory and Fitzpatrick 1992; Reitzes et al. 1991; Ward et al. 1988). Reitzes et al. (1991) showed that while personal factors such as physical health and personal assets were important for overall well-being, place of residence was even more important. Most notably, the well-being experienced by elderly people living in cities was significantly lower than for those residing in suburban or rural areas. As noted in Chapter 3, cities concentrate diversity, strangers, and highly complex environmental stimuli. Older persons may perceive principal-city spaces and organizations as large, impersonal, and threatening, and thus participate less actively with their surrounding environment (Reitzes et al. 1991). The negative aspects of urban location, however, may not always outweigh the benefits accruing to residents in certain parts of the central city.

The accessibility of an area to other places (good, reliable, and available transportation) is also a critical factor in both general well-being and levels of depression, particularly for the less healthy elderly (Aneshensel et al. 2007; LaGory and Fitzpatrick 1992; Lang et al. 2009). The central city may be convenient for some residents, even more convenient than

suburban and rural communities. In the case of disadvantaged neighborhoods, however, accessibility may be extremely problematic. These areas can promote higher levels of depression and lower levels of well-being for vulnerable elderly because they are essentially cut off from access to other parts of the metropolis due to high crime, fewer personal forms of transportation, and high levels of mistrust. Lack of access may also exacerbate the physical health risks associated with the frail, less competent elderly. This group of individuals is usually not just physically disabled but also socially, economically, or environmentally impoverished as well. These deficiencies may be extremely low income, incomplete care-giving arrangements, limited social contacts with friends or family, inaccessible homes for persons with disabilities, or inconvenient, high-crime neighborhoods that limit people's ability to effectively use their surroundings.

Conclusion

These four groups: the homeless, the poor, youth, and elders, experience similar spatial constraints. They are more dependent on others to gain access to opportunities afforded in other parts of the metropolitan area. Their constrained action spaces limit their options and experiences, and reduce the ability of the city to work effectively for them as a "machine for living." At the same time, because of limited action spaces, their health is more likely to be threatened by the hazards and risks present in the local residential area. Clearly, place matters more for them than for others, and their place in the world is governed by both geography and their unique physical, psychological, and social circumstances.