

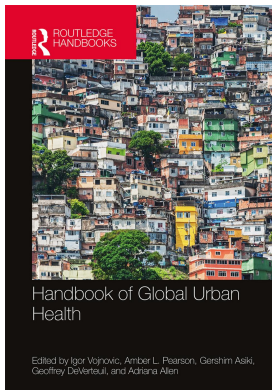
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URBAN MENTAL HEALTH

*James Lowe***Introduction**

This chapter will tell *a* tale—there being multiple tales to tell—of the geography of mental health and the city. As such, it is necessarily partial. It will focus on how mental *ill*-health has been represented and understood in contemporary and historical urban health discourse in the Global North—primarily Canada, the USA, and the UK, which share a common experience of inner-city poverty, deinstitutionalisation, and the material decline of the welfare state—and how the development of this distinctive *geographical* approach to questions of mental health and the city has aided this task. It begins with a discussion of how incidences of mental ill-health have been found to be unevenly distributed across urban space. It looks at the associated theoretical constructs that have been used to explain these findings, with a focus on social and economic deprivation and/or residential mobility as explicatory factors. It emphasises the importance of the welfare state in underpinning these urban mental health geographies through an examination of the ways in which the policy of deinstitutionalisation of hitherto confined populations, on the one hand, and a systemic retrenchment of the welfare state, on the other, have created alternating geographies of neglect and support that serve to deepen inequality and cement its spatial expression in place. It finishes by setting against this contextual backdrop contemporary research findings on the lives of present-day mental health service users as they navigate an urban environment dominated by instability, insecurity, and the progressive withdrawal of the public services and facilities around which they have so often orientated their lives.

Mapping Mental Health Distributions***Social Causation and the Urban Ecology of Mental Illness***

Early geographically based investigations into mental health—ironically enough often conducted by non-geographers—established that the incidence of mental ill-health varied dramatically across urban space, with a noted concentration of serious mental ill-health such as schizophrenia and substance abuse disorders in and around the urban core (Faris and Dunham 1939; Hardt 1959; Hollingshead and Redlich 1953; Hyde and Kingsley 1944; Schroeder 1942). This prevalence declined steeply as distance from the inner city increased, with proportionately far fewer psychiatric patients hailing from the outer, more prosperous suburban areas than from the economically distressed inner core.

Two broad schools of thought developed to explain this central finding. In the first, researchers attributed this clustering pattern to the impact that the social and physical conditions of the inner

city—those ‘deteriorated regions in and surrounding the center of the city’ (Faris and Dunham 1939, p. 35)—had on its residents in places including Chicago (Faris and Dunham 1939), Bristol (Hare 1955), Buffalo (Lapouse et al. 1956), North-East London (Mezey and Evans 1970), New Haven, Baltimore, Durham, NC, and Los Angeles (Silver et al. 2002). In this view, life in the hardscrabble urban core played out against a background of physical dilapidation and was dominated by impoverishment, instability, exclusion, and isolation. This terrain created an ecology that, in effect, incubated and exacerbated mental illness, which would subsequently flourish in those for whom the daily battle for survival had taken its greatest toll. The extent of their greater exposure to this inhospitable environment rendered inner-city residents (or even predisposed them to be) more susceptible to developing serious mental illnesses than their suburban counterparts. As one such study noted of Nottingham, it is in ‘inner, slum areas of the city’ where

a whole set of unfavourable life circumstances, notably low social status, high unemployment and low social cohesion . . . collectively assume their greatest intensity . . . Here, as in other large cities, there are pathogenic areas which seem to destroy mental health.

(Giggs 1973, p. 71)

Returning to the mental health geography of the same city over a decade later, Giggs (1986) found an enduring concentration of schizophrenia in the inner city and other deprived and semi-suburban localities:

This persistence is remarkable, for the massive slum clearances and local authority housing rebuilding programmes of the late 1960s and the late 1970s has dramatically altered and improved the quality of the built and living environment in large tracts of the inner city.

(Giggs 1986, p. 959)

Indeed, in their 1993 study, Dauncey et al. were able to conclude that in Nottingham there remained a ‘significant relationship between schizophrenia and a tendency to originate in areas of urban deprivation’ (p. 618), findings echoed by Curtis et al. (2006), who found that hospital admission rates for acute psychiatric conditions in both London and New York City were positively and significantly associated with levels of deprivation independent of local demographic factors or questions of ease of access to hospitals.

Other studies moved away from an emphasis on the ecology of the inner city, focusing instead on the social and economic characteristics of neighbourhoods or households/individuals, and using multi-level models and advanced methods of longitudinal data analysis. For example, in their study, Propper et al. (2005) determined that for common mental disorders the characteristics of individuals were the most important: ‘it is people, rather than place, that matter’ (p. 2080). Similarly, Weich et al. (2005) drew out the role that household features might play in addition to individual and neighbourhood characteristics. They found that whilst deprivation indices at the electoral ward level in Britain did not influence the inception and maintenance of common mental disorders local factors at the household level did. The difficulty—or impossibility?—of delineating precisely how neighbourhood factors or individual characteristics interact with or determine mental ill-health accounts for the continuing research in this field (see Mair et al. 2008 for an overview).

Social Selection: Mental Ill-Health and Residential Mobility

In the second school of thought, researchers questioned the idea that the conditions of the inner cities *alone* caused the onset of mental disorder and its concentration in these geographical localities. Instead, this research focused on the role that residential instability and mobility—such as physical

migration to or from the inner city or mobility up or down the socio-economic scale—might play, and suggested that the concentration of large numbers of individuals with mental health problems in the inner city was largely the outcome of a complex process of spatial ‘filtering’ (see, for example, Dean and James 1981; Gerard and Houston 1953; Goldberg and Morrison 1963; Gudgin 1975; Turner and Wagenfeld 1967). It held that, in a deprived locality largely devoid of amenities and opportunities, the more upwardly mobile of inner-city residents would consciously seek to leave. Those remaining, who lacked either the wherewithal or the ability to leave, would be subject to a form of ‘social stagnation’ that served to further limit their ability to take advantage of any future opportunities to move. These residents would, over time, be joined by others who, subject to downward social mobility and/or the onset of mental health problems, would either ‘drift’ or consciously move into the inner cities, where affordable accommodation was available, and the existing residents lacked the political heft to restrict residential access to their neighbourhoods. This systematic ‘pooling’ of needy individuals in the inner cities would, in time, result in a concentration of social and medical services in the urban core which, in turn, would act as a pull factor for further ‘service-dependent’ individuals to follow suit and relocate to the inner city.

McNaught et al. (1997) analysed the residential mobility of individuals diagnosed with schizophrenia living in an area of North London in 1986 and 1991. They found that, whilst the number of individuals diagnosed with schizophrenia was similar in both the 1986 and 1991 surveys, only half of those identified in the 1986 survey remained in 1991; those who left had been replaced by other individuals who had moved into the area, often from outer London, and whose personal residential histories included a significant number of moves. In North America, Dembling et al. (2002) in Virginia, and Lix et al. (2006) and DeVerteuil et al. (2007) in Winnipeg, found that individuals experiencing serious mental health problems were more likely to move than the general population and to be moving in a counter-direction to general trends of urban population movement (essentially moving toward the inner city as the general population headed outwards). In New York, Curtis et al. (2009) found that proximity to hospital care was associated with higher rates of hospital use and posited that an element of drift could in part be responsible. Support for drift theories in North America also come from Breslow et al. (1998), who found that heavy users of psychiatric services in Albany, New York moved to be close to the area in which the services were offered, and McCarthy et al. (2007), who found similar results in Virginia; see Löffler and Häfner (1999) for evidence from Germany, and Timms (1998) from Sweden.

The ways in which the residential mobility of people experiencing mental health problems may intersect with, or be determined by, the nature and structure of service provision, and in particular admission to hospital, is extensively chronicled: see, for example, Shern and Dilts (1987) in Denver and Tulloch et al. (2011) in South London. Also in London, Lamont et al. (2000) found that rates of residential mobility for individuals experiencing serious mental ill-health and subject to admission to hospital were higher than for those under the care of community mental health teams; and those resident in the inner city were significantly more likely to display unstable residential patterns than those resident in outer boroughs. In a detailed examination of the problems residential instability causes for continuity of patient care, they note how the management procedures and cultures of hard-pressed psychiatric services can exacerbate these problems. They underline that community mental health services are:

increasingly examining the status of patients before they are taken on for care, and those who are in very unstable accommodation are often not taken on by the local teams on the grounds that they are likely to move shortly . . . [resulting in] a sub-population of highly mobile patients—*rootless and generally unwanted in an overcrowded metropolis*—who use a disproportionate amount of in-patient services and add significantly to bed pressures.

(Lamont et al. 2000, p. 168, *emphasis added*)

Highly 'geographically mobile' individuals were found to have longer stays in hospital than their more geographically stable counterparts, and Lamont et al. acknowledge the worrying implications for patients' potential future residential stability following discharge, noting that

[p]atients with severe mental illness are often evicted at the point of admission and therefore have a geographical move forced on them at the time of discharge. If the move is to another area with different mental health services, it is easy to see how a cycle of readmissions can develop.

(Lamont et al. 2000, p. 168)

Other research has, however, questioned whether residential mobility per se should be represented as always constituting a negative outcome for individuals with mental health problems and have instead asked if, in certain places or circumstances, its counterpart—residential immobility or entrapment—might be seen to represent a greater threat to mental health (Drukker et al. 2005; Ross et al. 2000; Whitley and Prince 2005). Ross et al. (2000) claim that, in 'affluent neighbourhoods, stability is associated with low levels of distress; under conditions of poverty the opposite is true' (p. 581). They argue that areas of high socio-economic deprivation will often see higher levels of social disorder and that, for these areas, unlike more affluent ones, stability does not result in lower levels of social disorder. Residents therefore may feel powerless to leave, and their entrapment in such places can have deleterious impacts on their mental wellbeing. With distinct echoes of the ideas of the ecological school of thought, these deprived areas are representative of neighbourhoods of 'last resort, where people remain, not because they choose to, but because they have no other options' (Warner and Pierce 1993, p. 499).

The Role of the Welfare State

Urban mental health distributions are structured by certain patterns of residential mobility but also conditioned by the policies and operation of the welfare state. In particular, it is the policy of deinstitutionalisation and the concomitant geographies of neglect and support that this engendered (examined below and in the section which follows) that underpin contemporary mental health geographies in the city. Mental health service users frequently find themselves remote from networks of family support and often have at best only tenuous links to paid employment. Thus, the welfare state—especially its ability to provide a meaningful income to mental health service users—assumes a strategic and tactical importance in their day-to-day lives, an importance which is reflected in the concentration of services and resources in cities.

Policy Responses: Deinstitutionalisation and the Service-Dependent Ghetto

The persistent finding of concentrations of people with serious mental health problems in the inner cities had by the 1970s drawn researchers to investigate the role that the welfare state and its agencies might play in influencing these outcomes. In essence, this meant looking at the practice and consequences of the policy of deinstitutionalisation, which had led to the rapid discharge of the majority of psychiatric patients from asylums and other institutions to alternative forms of community mental health provision. Deinstitutionalisation saw ex-psychiatric patients swelling the ranks of existing vulnerable and impoverished populations in poorer inner areas of the cities. Researchers now sought to connect the movement of ex-psychiatric patients to the inner cities—and the development of 'psychiatric ghettos'—with the wider and more profound patterns of urban economic structural and spatial change then in their infancy.

This work set about exploring the emerging spatial relationship between discharged populations ('the mentally ill'), the local communities into which these populations would be discharged, and the state and its role in managing the transition from asylum to community. These spatial patterns were forged against an unfolding backdrop of radical economic restructuring: urban industrial decline and the migration of revenue-generating businesses and households out of cities to their suburban peripheries. These spatial-economic processes threatened 'a self-reinforcing cycle of neighborhood decline and service-dependent concentration' (Wolch 1980, p. 333), with a residual population in the inner city dependent on public welfare to meet its daily needs: what Dear (1980) termed 'the public city', in which the interlocking processes of discharge, patient drift to the inner city, and resulting provision of public services are not 'some arbitrary creation resulting from the aggregation of many individual service-dependent decisions, but a structural feature which is both functional and convenient in contemporary urbanization' (p. 231). This creation of a 'service-dependent ghetto' caused consternation among urban researchers, who worried about the consequences of the 'clear debasement of the urban condition' they were observing (Wolch 1979, p. 271).

One of the first attempts to delineate the service-dependent ghetto was that of Dear (1977a), who used a case study in Hamilton, Ontario to illustrate the wider consequences of the policy of deinstitutionalisation now in progress across North America. He too found that, post-discharge, patients congregated in the city's downtown core, with its plentiful supply of cheap short-term accommodation—the type of lodging described as "seedy residential hotels" in "the dumping ground of the disadvantaged" (Wolpert and Wolpert 1974, quoted in Smith 1975, p. 53). This concentration was either a result of their direct assignment by the discharging hospital to downtown accommodation, or a consequence of their having drifted there from other, initial discharge locations elsewhere in the city. Dear claimed that the volume of individuals being discharged under the policy of deinstitutionalisation, and the hastily made arrangements for doing so were placing great strain on community mental health facilities, and 'have essentially transferred the hospital backwards into small scale community-based settings . . . [and resulted in] an increasing resistance to community psychiatric facilities' (Dear 1977a, p. 589).

It was the hostility—based largely on fear, stigma, and prejudice—shown by the receiving communities to the idea of accommodating deinstitutionalised patients in their midst that helped explain both the forced and the voluntary concentration of ex-psychiatric patients in the inner city and the concomitant rise of the 'psychiatric ghetto'—geographical trends that were 'manifestations of the development of a new "asylum"' (Dear 1977a, p. 594). Importantly, however, Dear allowed for the possibility that this 'asylum without walls' might have both negative *and* positive aspects for patients, not least in the provision of public facilities and services. And further, echoing Smith (1975, p. 53) ('What is it like to be mentally ill? What does it mean to be hospitalized and to be released into an unfeeling community?'), Dear suggested that the views of patients themselves should be taken into account before decisions were made by policy makers and service providers about how formally to respond to the presence of the psychiatric ghetto.

In their book *Not on Our Street*, Dear and Taylor (1982) delved further into the key role played by local communities in the creation of the post-asylum geographies now being mapped in North America. Bringing location theory more formally into contention, they noted 'the explicit recognition of nonuser attitudes to facilities as a vital consideration in locational decision-making' (Dear and Taylor 1982, p. 4). Those planning community mental health services and facilities all too frequently fell foul of 'non-users', whose invariably virulent opposition to the siting of such facilities in their neighbourhoods was contributing to a crisis in the level of community mental health provision. Ex-psychiatric patients themselves were powerless bystanders suffering the collateral damage. For comparable studies in the British context see, for example: Burnett and Moon (1983); Eyles (1988); Huxley (1993); Moon (1988); Parr (1991); and Sixsmith (1988). The power exerted by this NIMBY (Not In My Back Yard) sentiment, allied to the fiscal squeeze about to commence in

public welfare provision, particularly in North America, was to have devastating consequences for people experiencing mental health problems as the 1980s unfolded.

From the Service-Dependent Ghetto to a Landscape of Despair

Building upon their previous work (Dear 1977a, 1977b; Dear and Taylor 1982; Wolch 1979, 1980, 1981), Dear and Wolch (1987) catalogued this catastrophic collapse in the life circumstances of deinstitutionalised psychiatric patients and other welfare-dependent and vulnerable populations in their landmark *Landscapes of Despair*. Using a conceptual framework grounded in theories of structure and agency, it elucidated the outcome of the complex interplay between society and space. In almost forensic detail, the authors catalogued the ways in which the *social process* of deinstitutionalisation begat a *physical manifestation*, the service-dependent ghetto. This is ‘functional for the deinstitutionalized; it is a spatially limited zone where individual support is made possible through proximity’ (Dear and Wolch 1987, p. 21).

Almost immediately, however, the service-dependent ghetto was to encounter the unyielding social force of economic restructuring and deep fiscal retreat by the welfare state, in which ‘[t]he new community care is characterized by a plethora of political jurisdictions and is currently besieged by a system-wide retrenchment’ (Dear and Wolch 1987, p. 102). A reduction in the rate of welfare payments to individuals, a shrinking and more competitive market for affordable accommodation, and, in the face of continued suburban obstinacy, an increasing unwillingness on the part of city authorities to provide services for more than their ‘fair share’ of the needy resulted in the stealthy dismantling of the service-dependent ghetto. The immediate consequence of this was a ‘crisis’, both figuratively, in the tatters of the ‘failed’ policy of deinstitutionalisation (or ‘care in the community’ in the UK context), and literally, in the urban iconography of daily hopelessness, unmet psychiatric need, and homelessness: the ‘landscapes of despair’ from which the book took its evocative title.

With levels of homelessness reaching endemic proportions in North American cities—particularly in California—Dear and Wolch (1987) foresaw the crisis as prefiguring a return to institutionalisation as a formal policy response. In California, they noted that, following their displacement from the fractured service-dependent ghetto, the deinstitutionalised were to be found circulating through an ever-increasing number of institutional and often inappropriate penal or carceral settings, or else were enduring ‘the pathology of everyday life on the streets’, an experience which ‘is actively creating a new set of social problems that are likely to perpetuate a crisis of homelessness’ (p. 199). In response, the authors suggested that if deinstitutionalisation can be viewed as a ‘failure’ it is because its implementation took place under markedly different social and economic circumstances to those which prevailed at its conception, and because the abdication of responsibility by wealthier suburban communities left financially floundering city authorities shouldering an unsustainable burden. Though pessimistic about the chances of it coming to fruition, Dear and Wolch suggest that, rather than pursue a return to the same, or indeed new, forms of institutional care, deinstitutionalisation should instead be made a ‘reality’, through the dispersal of responsibility and resources more equitably across geographical space: ‘Though location *in* the community does not guarantee support *by* the community, dispersion can facilitate the kind of social integration that ghettoization constrains’ (Dear and Wolch 1987, p. 202).

Dear and Wolch’s (1987) searing indictment of the tragic outcome of deinstitutionalisation in North America has long been considered a landmark text (see DeVerteuil and Evans 2009 for a thorough appraisal of its legacies), though the applicability of the concept of the service-dependent ‘ghetto’ beyond North America has been found wanting. For example, Milligan (1996) argued that in Scotland the legislative foundations of the policy of deinstitutionalisation, coupled with greater centralised planning and control and a more powerful voluntary sector, ensured that the post-asylum landscape differed significantly from that commonly observed in North America: instead

of a 'ghetto', services and the populations dependent upon them had in fact been scattered quite widely, and these services and facilities had encountered significantly fewer NIMBY-esque objections. Similarly, in New Zealand Gleeson et al. (1998) reported a more dispersed service-dependent population as a consequence of higher levels of welfare provision (in particular social housing), lower levels of overall inequality, and the particular legislative and administrative outcomes of welfare reform (see Kearns and Joseph 2000).

Nevertheless, as a work of scholarship, *Landscapes of Despair* (Dear and Wolch 1987) represents something of an apex of attempts by geographers in the 1980s to synthesise urban geographies of mental health within a political-economic framework. The research of this period revealed how the enduring concentration of mental ill-health in inner cities was a spatial expression of the larger social and economic processes that reverberated through Western societies throughout the 1970s and 1980s. These new mental health geographies not only showed these macro-processes at work, but also began to display a tangible concern for the lives, and life chances, of the individuals—mentally ill and service dependent—at the sharp end of powerful forces well beyond their control. This sense of people with mental health problems being seen as *subjects*—albeit largely as economic victims—rather than epidemiological data points helps elucidate the ways in which the research agenda into mental health and the city changed once more and, in so doing, yielded further insights into not only the phenomenon of mental health and the urban environment, but the *experience*, and in particular the experience of homelessness and certain mobility practices associated with it.

Mental Health and Homelessness: Abandonment and the Institutional Circuit

Far from random, homeless mobility in the 1990s was largely shaped by the geography of human service providers such as drop-in centers, shelters, and transitional housing. The destruction of many skid row districts notwithstanding, most homeless services are channelled to poorer, heterogeneous inner-city neighborhoods through opposition from wealthier, better organized communities.

(DeVerteuil 2004, p. 393)

The urban mobility patterns of individuals experiencing mental health problems have often been represented as residential *instability*, whether as 'drift' to the service-heavy inner cities, or as the concept of hypermobility, in which individuals 'churn' through the revolving door of various institutional or community settings, and whose personal mental health histories are closely entwined with periods of psychiatric treatment, particularly inpatient treatment, and with periods of street homelessness.

Unsurprisingly, perhaps, individuals with mental health problems have been described as the most poignantly visible group to swell the ranks of the street homeless (Sullivan et al. 2000). A remarkable illustration of the extent of this poignancy can be seen in research by Knowles (2000). She shadowed the lives of people with serious mental health problems who, having been effectively abandoned by the welfare authorities, were living highly marginal lives on and around the streets of Montreal. In the absence of any serious community mental health support or direction, individuals scabbled together survival routines across both public and *private* spaces of the city that provided for those daily needs that remained resolutely unmet by the retreating public welfare authorities. She described their predicament:

There is no special place in this city for the mad. They must stay on its edges, use its fast food joints, malls, churches and the streets on uncertain terms. Their lives are organised through a patchwork of facilities, none of which is especially about (i.e. designed for) them

or their needs. Not the clients of a modern welfare state and its sophisticated psychiatric services, these are people administered through the revamped relic of 19th century religious philanthropy and the doughnut shops of the global age.

(Knowles 2000, p. 223)

The intention of this subsection is to focus on the complex interplay between the state and its policies and institutions, and the life circumstances of individuals with mental health problems so as to illuminate the *spatial* outcomes. In their investigation of the connections between homelessness and mental illness among a sample population in New York, Hopper et al. (1997) emphasised the importance of large statutory agencies in operating to prolong and/or deepen residential instability and homelessness. They argued that, in addition to individual risk factors and broader structural, social, and environmental conditions, ‘homeless service systems’ and their ‘street-level bureaucrats’ played a pivotal role in shaping an ‘institutional circuit’ in which individuals would be increasingly directed to impromptu and inappropriate residential settings which, moreover, ensured their clients ongoing patterns of extreme residential instability as they churned through the system: ‘[D]e facto “solutions” to precarious housing—shelters and custodial facilities linked to haphazard chains of time-limited occupancy—should be considered among the inertial forces that sustain homelessness among persons with severe mental illness’ (Hopper et al. 1997, p. 659).

That institutions neither are neutral nor stand aloof from social outcomes but rather play an active role in sustaining homelessness amongst individuals with mental ill-health (as well as more generally) echoes the work of the political-economy approach to mental health geography. DeVerteuil (2003) demonstrates how the state and private and voluntary institutions involved in providing services and facilities for poor and disadvantaged populations (including the homeless and residentially unstable people with mental health problems) in Los Angeles have since the 1980s become partially co-opted by macro-policy imperatives which emphasise the management of scarce resources over the provision of assistance. This policy framework represents a deliberate strategy in which institutions and organisations formerly dedicated (at least ostensibly) to the amelioration of hardship must instead now manage, coerce, and occasionally mitigate the life circumstances of poor and potentially disruptive populations:

This new poverty management is based on large-scale global and national dislocations . . . Within the United States this shift has engendered a countercyclical retrenchment and devolution of the national welfare state, beginning in the 1970s and accelerating during the Reagan–Bush years. Under pressure to respond, institutions sought to minimize caseloads and costs, as well as to privatize services. The resulting fragmentation of service providers, lack of an explicit continuum of care, and expedient cutbacks encouraged the circulation and institutionalization of so-called ‘disruptive’ populations across a diverse array of unrelated, time-limited settings—including standard residential dwelling units, shelters, jails, prisons, hospitals, rehabilitation centers, single room occupancy (SRO) hotels, and the street.

(DeVerteuil 2003, p. 361)

Here, then, the response of the state to the challenges posed by individuals with severe mental health problems, the homeless, and other marginal or ‘difficult’ populations is to repeatedly shoehorn them into an ill-fitting and ill-equipped system, one that alternates between institutional control and community indifference, and the outcome of which is at best the maintenance and at worst the nourishment of the exclusion and alienation these groups must endure (Craig and Timms 2000).

Wilton (2003) and Mifflin and Wilton (2005) provide further evidence from case studies in Ontario. There, state and federal housing and welfare reform policies deepened the poverty of individuals with mental health problems and in so doing fatally undermined the efforts of *other*

government policies aimed at enhancing the quality of individuals' lives and reducing the levels of stigma associated with mental illness. This should not be a surprise, however, as under the neo-liberal welfare orthodoxy promulgated in North America and the UK 'welfare state restructuring is promoting the further defunding of the poor', including the withdrawal of benefit payments that help promote residential stability (DeVerteuil 2005, p. 385). One of the implications of this system of crisis management is a form of hypermobility undertaken by homeless individuals with mental health problems as they circulate across spaces both public and private and are churned through institutional settings (DeVerteuil 2003, 2004; Hopper et al. 1997; Knowles 2000). As outlined earlier, however, mobility per se is inherently neither positive nor negative. For people with mental health problems, the inclination of others is, understandably, to view these more frenetic forms of mobility as embodying the seemingly inevitable consequences of individuals' powerlessness in the face of much stronger forces. However, through a different lens it is possible to see aspects of hypermobility as representing the best opportunity to meet basic needs:

[T]he tenacious, stressful, and sometimes ingenious, strategies for securing basic needs evolve into patterns of subsistence . . . Given the extremely constrained residential opportunities of the very poor, a strategy of *voluntary mobility* may be indispensable in avoiding utter destitution and literal homelessness.

(DeVerteuil 2003, p. 363)

Thus mobility, as a self-determined response by individuals to particular daily circumstances, can involve a modicum of agency on the part of individuals. Nevertheless, mobility as a *daily strategy* is unlikely to meet the *longer-term* welfare needs of individuals (DeVerteuil 2003). Instead, it contributes to

a deepening sense of fragmentation and lack of belonging, adding further layers of distress. It is not that mobility itself inherently produces uncertainty and distress: like others, the mad treat global, national and urban pathways in making their lives as a sequence of places in time. But the *nature of the urban pathways that they tread* and the *purposes of survival* for which they tread them likely adds layers of stress, uncertainty and dislocation to already difficult lives.

(Knowles 2000, p. 222)

Within this mobility there are carefully constructed nuances relating to specific circumstances in which freewill could reasonably be said to be enacted, as opposed to those in which individuals choose mobility as the least bad option, or are left with no choice at all: 'We can and must recognize the homeless as active agents. We must also document the multiple ways in which the state regulates them so extensively that their navigation of movement becomes a perpetual and often fraught challenge' (Herbert 2010, p. 259). Precisely how mobility is figured depends in large part upon whether it is seen as being undertaken voluntarily or is enforced. It must also be situated within the broader 'constellation of power relations' inherent in all spatial practices (Gilbert 1998, p. 596). The precise lines of demarcation in these power relations are unclear:

Clearly, the relationships between mobility/immobility and power/powerlessness (ie, mobile is to powerful as immobile is to powerless) do not operate in the same way for different groups in and across space-time. Although more power (eg gained from court rulings) might afford more mobility (eg citizens' inter-state migration), more mobility (eg homeless people forced to vacate public space) does not impart more power.

(Jocoy and Del Casino 2010, p. 1947)

So, while the hypermobility of individuals with mental health problems is part of a self-determined strategy that allows them to furnish their basic needs of survival, the ability to be mobile does not automatically endow them with greater power, not least because of the severe limitations placed on the exercise of individual agency under the iniquitous circumstances of the new poverty management framework (a framework which is increasingly reflected in welfare reform in the UK):

[T]his circulatory tendency is exacerbated by a critical lack of affordable housing and a revanchist urban realm. As a result, vulnerable groups such as the mentally disabled involuntarily cycle across unrelated (institutional) settings—victims of a ‘revolving door’ policy. Along the way they encounter a series of inadvertent, informal, and inappropriate institutional settings. For instance, many mentally disabled individuals find themselves in settings that offer no mental health treatment or services . . . As institutional cycling becomes a way of life, the mentally disabled become institutionally dependent, adapting to the rhythms of these settings.

(DeVerteuil 2003, p. 364)

The research presented here provides a crucial insight into the complex interaction between the exercise of mobility by individuals with mental health problems and the social relations under which this operates: ‘neither powerful/powerlessness nor placelessness/containment map cleanly onto dichotomies of mobility/immobility. In some cases, empowerment lies in increasing mobility, in others it lies in enabling settlement’ (Jocoy and Del Casino 2010, p. 1961).

This section of the chapter has sought to marshal the ample evidence of the disproportionate concentration of mental ill-health in inner urban areas, and the theories and approaches which have sought to explain it. By concentrating on economic urban restructuring and the response of the state, and specifically the policies of deinstitutionalisation and welfare retrenchment, these geographies deepen our understanding of the reasons behind the continuing lopsided distributions of mental ill-health toward the inner cities. Equally important, they also highlight the human and social implications for those at the sharp end of the process. The main absence from the existing literature is that, while we know how people are residentially mobile, we rarely know why: what is missing is research which probes more deeply residential mobility as it is felt and understood by mental health service users themselves, and which attends to and accounts for their social circumstances and how they relate their experiences of life in the inner city to their mental health. Such accounts are the subject of the following section.

‘Neglect in a Bedsit’

We don’t call it care in the community. We don’t even call it neglect in the community. We call it neglect in a bedsit.

(Male mental health service user, late 40s)

The last decade has seen a sustained attempt by successive UK governments to substantially ‘reform’ the welfare state and, in so doing, to recast its relationship with those most reliant upon it. This reform, which includes restrictions on entitlement (including reassessments for ongoing entitlement) to sickness and disability benefits, a focus on ‘work-led’ recovery, fundamental changes to the system of housing support for low-income people, and a shrinking of (in)formal day-to-day services that aim to ameliorate the daily living conditions of vulnerable residents in urban areas, has generated new interest in examining how the changed/changing welfare environment is impacting the lives of service users in contemporary Britain.

Intensive, qualitative research conducted in 2014 and 2015 by the author (Lowe 2017) further elucidates the relationship between mental health service users and a post-deinstitutionalised and increasingly welfare-strained urban environment, and shows the continued relevance of *mobility* as an aid to understanding these experiences. In-depth interviews with 25 service users over the course of 18 months revealed an array of experience, including current, incipient, previous, or feared homelessness:

When I was made homeless I was very vulnerable. It was a very, very horrible experience. You had to look over your shoulder the whole time; you had to obviously keep everything secure. I had one shopping trolley, I had a holdall thing, and I had a rucksack. So I was carrying these things nearly everywhere I was going.

(Male mental health service user, early 40s)

I laid in bed for days at a time, like a hermit. I would go to the pub to use the toilet. It was much better than the hostel facilities, and I used to go to the swimming pool to shower.

(Male mental health service user, early 40s)

Eviction and displacement were predictably commonplace:

I was made homeless during the run-up to the Olympics when landlords were getting extortionate rents. The same day you are evicted you go to the council and they give you temporary accommodation which, before you even see it, you have to accept, and this was the place. It was a nightmare. I became really ill.

(Female mental health service user, late 50s)

Well, I'm essentially going to be made homeless, yeah. That means going into a hostel or bed and breakfast and sort of going back to the beginning again.

(Male mental health service user, 40s)

This abetted circulation across a variety of inadvertent settings:

Instinctively now I know the areas to avoid, areas where the crack addicts are. I naturally avoid the bad areas. I will plan my routes, navigate through the nicer areas. When you come out of my flat don't turn right, turn left. Always go left. I live 90 seconds from a block of flats where there are crack houses and murders. You go 90 seconds the other way, there's another block, and you'll see beautiful blondes driving open top Porsches into an underground car park.

(Male mental health service user, late 40s)

The police found me wandering round the streets and started to investigate me and I got taken in. I was there from about 4 p.m. I got taken in, something like that. I must have moved in the middle of the night. And I had two doctors section me and I was taken off to [name of psychiatric hospital].

(Female mental health service user, early 50s)

Because of the harassment of my neighbours I am reluctant to go out of my front door and be in the vicinity of my block of flats, so I don't take my rubbish out and my rubbish has built up and up. I can't stand living there and I have no prospect of moving. For me, my flat is a prison. The only reasons I am not dead is that there are no ligature points in my flat.

(Male mental health service user, late 40s)

What became apparent is the degree to which service users' lives were governed by residential instability, that is fear and trepidation over actual or even potential residential mobility. For those who had been residentially mobile, the most important factor in how it was experienced and subsequently reported was the extent to which it was undertaken voluntarily or involuntarily, with the latter representing powerlessness and being associated with negative residential examples of displacement, homelessness, and circulation (including repeated hospitalisations) and with poor mental health. This sense of powerlessness was similarly implicated in instances of residential immobility in which feelings of abandonment, entrapment, and mental distress dominated.

Service users' residential circumstances do not, of course, exist in isolation from other factors or influences, and the research also showed that one of the key variables that impacts their residential mobility is entry into, and an ability to continue to hold on to, stable, suitable accommodation: an ability in grossly overheated property markets such as inner London that is ever more dependent upon income. With the majority of service users interviewed absent from the labour market, this means instead access to meaningful, regular, and reliable welfare benefits. Substantive changes have been made to UK social welfare benefits which, taken together, loosen the safety net that helps to sustain the mental health of service users more cost-effectively than would prolonged stays in hospital or the kinds of odysseys through the plethora of residential settings that have been noted in the research discussed in this chapter.

Conclusion

This chapter has shown the ways in which a spatial lens can help illuminate our understanding of the intersections between mental ill-health and the city environments. It has outlined the large body of research—across geography, sociology, epidemiology, and psychiatry—that has considered the urban dynamics of mental health, and has examined the theoretical models that have been generated to try to explain these dimensions. It focused in particular on that work which has sought to interrogate the policy of deinstitutionalisation and its impact on the urban realm, and emphasised the importance of the concept of residential mobility in deepening this understanding. It also called for greater attention to be paid to the lived experiences of mental health service users, and to set these in the context of the sagging welfare safety net.

Overall, then, the urban realm can be seen as indispensable in understanding mental ill-health. It has permitted a concentration of services that would be unsustainable in less densely populated locales, it has a history of offering more affordable accommodation than found in suburban areas (though this is no longer true of London or some of the other large, globally orientated cities discussed here, which is a fruitful avenue for future research), and it has offered at times greater freedom of mobility and some—albeit only partial and temporary—relief from the stigmas historically associated with being mentally ill.

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