PSYCHIATRIC PATIENTS AND THE INNER CITY*

MICHAEL DEAR

ABSTRACT. Inner portions of North American cities may be becoming the location of an asylum without walls for psychiatric patients discharged from mental hospitals. This trend represents an organic outgrowth from the moves to diminish the role of the mental hospital and to encourage a community-based mental health. Discharged patients are comparatively mobile and a large proportion of them filter through urban space to an inner city location. This is a result both of formal placement procedures and of an informal process of spatial filtering within the inner core.

THE inner city has long been a focus of geographical analysis. It is the locus where many dramas of social and economic change have been resolved.[1] One current phenomenon of increasing prominence is the tendency for psychiatric patients discharged from mental hospitals to congregate in transient areas of the inner city core.[2] In many ways, the discharged patients resemble other minority or immigrant groups who have gravitated toward transient areas of cheap rental accommodation in order to "establish" themselves. The mentally disabled, however, usually lack the skills to spiral upward along with other self-improving groups. Those discharged from hospitals tend to be chronic patients (e.g., schizophrenics) who require longer term care and find difficulty in organizing to better their situation.

The "ghettoization" of the mentally disabled is a source of much concern for health care planners. As Reich has observed:[3]

> Most of the mentally ill are referred to cheap single-room-occupancy hotels and rooming houses, found largely in the decaying portions of inner cities. They share this space with prostitutes, discharged prisoners, and drug addicts. As the mentally ill are the weakest group, they fall easy prey to the predators of our society who victimize, terrorize, and otherwise physically abuse them.

Elsewhere, it has been suggested that there is little intrinsically wrong with the ghetto; on the contrary, it might even provide a supportive "asylum without walls" for the discharged psychiatric patient.[4]

Apart from such functional considerations, the ghettoization process also represents a significant geographical problem, since it focuses attention upon the spatial filtering of a disadvantaged minority group in an urban community. What happens to such a group? How do they filter through space to the inner city location? What are the potential dimensions of the ghetto problem?

The purpose of this paper is to report preliminary findings on the geographical incidence of psychiatric patients in the inner city. Specifically, the paper summarizes the results of a follow-up study of a cohort of patients discharged from a psychiatric hospital in Hamilton, Ontario during the first quarter of 1975. Some tentative answers to the questions raised

Dr. Dear is Assistant Professor of Geography at McMaster University in Hamilton, Ontario L8S 4K1, Canada.

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[1] Much evidence on recent trends in inner cities is contained in John S. Adams, ed., *Urban Policymaking and Metropolitan Dynamics: A Comparative Geographical Analysis* (Cambridge, Mass.: Ballinger, 1976).

[2] See C. J. Smith, "Being Mentally Ill—In the Asylum or Ghetto," *Antipode*, Vol. 7 (1975), pp. 53–59; and J. Wolpert, M. Dear, and R. Crawford, "Satellite Mental Health Facilities," *Annals*, Association of American Geographers, Vol. 65 (1975), pp. 24–35.

[3] R. Reich, "Care of the Chronically Mentally Ill —A National Disgrace," *American Journal of Psychiatry*, Vol. 130 (1973), pp. 911–12.

[4] This argument is pursued in Wolpert, Dear, and Crawford, op. cit., footnote 2; and in M. Dear, "Spatial Externalities in Locational Conflict," *London Papers in Regional Science*, Vol. 7 (1976), pp. 152–67.

TABLE 1.—PROVINCE OF ONTARIO: TRENDS IN MENTAL HEALTH CARE

	Psychiatric hospitals			Psychiatric units			Community mental health		
Year	Adm[a]	Disch[b]	Active[c]	Adm	Disch	Active	Adm	Disch	Active
1965	11,746	12,107	14,726	8,515	8,458	617	17,319	16,421	10,042
1966	13,368	13,594	13,753	8,687	8,645	645	17,994	16,501	11,450
1967	14,836	15,593	12,161	9,253	9,222	660	20,569	18,704	12,315
1968	16,128	17,536	10,024	11,118	10,919	910	28,605	21,794	19,126
1969	16,024	15,927	9,521	14,591	14,465	1,052	31,515	25,078	25,368
1970	15,712	15,868	8,838	18,914	18,820	1,118	37,536	33,729	28,156
1971	15,981	15,413	8,942	22,211	22,064	1,268	43,689	36,070	33,931
1972	16,090	15,968	8,695	23,005	22,985	1,226	46,651	36,257	44,237
1973	16,491	16,375	7,158	23,434	23,390	1,218	39,107	41,900	50,529
1974	15,729	16,263	6,161	26,794	26,702	1,340	49,417	47,660	53,637
1975	16,075	16,820	5,416	33,280	33,200	1,847	[d]	[d]	[d]

[a] Admissions.
[b] Discharges or terminations.
[c] Active cases at year end.
[d] Not available.
Source: Ontario Ministry of Health, *Hospital Statistics, 1974*, Tables 39 and 41; and Ontario Ministry of Health, unpublished data.

in the preceding paragraph are outlined, and the implications of the survey results are assessed.

CURRENT TRENDS IN MENTAL HEALTH CARE

The current trend toward community-based mental health care began in the mid-sixties in North America. The impetus for a community mental health movement derived from several sources, most notably the belief that long-term incarceration in mental hospitals did patients more harm than good, and that community-based care would aid in the social normalization of the disturbed patient.[5] As a consequence, there has been a tremendous shift in treatment modalities in mental health care. The trends in Ontario (our sample area) are typical (Table 1). The last decade has witnessed a strong increase in the active caseloads of community mental health services and, to a lesser extent, of psychiatric units in general hospitals. In contrast, the active caseload in psychiatric hospitals has declined continuously to about one-third its 1965 rate. At the same time, however, a much larger turnover in the psychiatric hospital census is evidenced by the growing volume of admissions and discharges.[6]

The trend toward a reduction in the number of patients resident in psychiatric hospitals has placed great stress on the alternative treatment modalities, especially the community mental health centers. Consequently, a wide experimentation with different kinds of treatment setting has occurred throughout North America. These experiments have included cooperative apartments, boarding homes, and homes for special care.[7] As might be anticipated, these new programs have had their share of problems. Often, for example, the discharge of patients has proceeded in haste, and the new residential facilities have essentially transferred the hospital backwards into small scale community-based settings.[8] It is hardly surprising, therefore, that many researchers have also reported an increasing resistance to community psychiatric facilities. Such neighborhood opposition is probably

[5] A. M. Freedman, "Historical and Political Roots of the Community Mental Health Centers Act," *American Journal of Orthopsychiatry*, Vol. 37 (1967), pp. 487–94; and D. H. Mechanic, *Mental Health and Social Policy* (Englewood Cliffs, N.J.: Prentice-Hall, 1969).

[6] Similar trends have been reported in the United States and in Great Britain; see, respectively, E. Wolpert and J. Wolpert, "From Asylum to Ghetto," *Antipode*, Vol. 6 (1974), pp. 63–76, and Kathleen Jones, *Opening the Door: A Study of New Policies for the Mentally Handicapped* (London: Routledge and Kegan Paul, 1975), especially chp. 1.

[7] A good summary is provided in A. Beigel and A. I. Levinson, eds., *The Community Mental Health Center: Strategies and Programs* (New York: Basic Books, 1972); more current evidence is found in L. D. Ozarin, "Community Alternatives to Institutional Care," *American Journal of Psychiatry*, Vol. 133 (1976), pp. 69–72.

[8] See, for example, H. B. M. Murphy, "Foster Homes: The New Back Wards?" *Canada's Mental Health*, Vol. 71 (1971), supplement; and H. R. Lamb and V. Goertzel, "Discharged Mental Patients—Are They Really in the Community?" *Archives of General Psychiatry*, Vol. 24 (1971), pp. 29–34.

linked to the continuing stigma attached to mental illness.[9] Communities' attempts to exclude the mentally disabled (both physically and socially) have prompted the development of strategies to minimize such opposition, and to persuade the community to adopt a more tolerant attitude.[10]

In spite of the burgeoning volume of studies on the changing mental health care system, the net impact of these changes has yet to be assessed. For the moment, most studies are content to analyze relatively simple issues, e.g., the comparative costs of hospital- and community-based care.[11] Only more recently are the complex social trade-offs in the system becoming evident.[12] One strong conclusion that has already emerged, however, is that there is likely to be a continuing need for the retention of a long-term residential alternative for the chronic patient. This has slowed the rush to close down the "snake pits," and a strong defense of the future role of the psychiatric hospital is being assembled.[13]

A SURVEY OF DISCHARGED PSYCHIATRIC HOSPITAL PATIENTS

Before a patient is discharged from a hospital, he or she normally is assigned to one of two kinds of post-release settings: institutional, and noninstitutional. The former includes halfway houses, foster homes, and homes for special care. The latter refers to placement with a family or friend, or to patients living alone. The type of patient assignment clearly has important ramifications in terms of future demands upon the health care system.

TABLE 2.—RESULTS OF SOME STUDIES ON THE DISPOSITION OF PATIENTS DISCHARGED FROM PSYCHIATRIC HOSPITALS[a]

Disposition	Clement $N = 761$	Lamb $N = 153$	Silverstein $N = 10{,}000$	Smith $N = 165$
Halfway House/ Boarding Home	3	35	[b]	25
Other Institution	8	9	6	[b]
Hospital	18	24	[b]	[b]
Transient	25	[b]	[b]	[b]
Institutional Sub-total	54	68	6	25
Alone	[b]	9	8	15
Non-Relatives/ Friends	[b]	3	5	4
Family	44	16	76	55
Non-Institutional Sub-total	44	28	89	74

[a] Figures are percentages.
[b] No directly comparable category reported.

Follow-up studies of discharged patients show a wide diversity in findings (Table 2). For example, Clement et al. discovered an approximately even split between institutional and noninstitutional assignments in a Greater Montreal sample of 791 patients. The former figure was inflated by a high proportion of transient patients (i.e., placed but awaiting reassignment) in the sample.[14] By contrast, in California, Lamb and Goertzel discovered a relatively low proportion (twenty-eight percent) of their sample in a noninstitutional setting. This might reflect the relatively long time (five years) which had elapsed since the release of their study cohort.[15] An even greater contrast is found in Silverstein's major study of the Pennsylvania program. He found that only six percent, of over 10,000 patients discharged, remained in

[9] J. Fracchia, "Public Perception of Ex-Mental Patients," *American Journal of Public Health*, Vol. 66 (1976), pp. 74–76; and Stewart Page, "The Elusive Character of Psychiatric Stigma," *Canada's Mental Health*, Vol. 22 (1974), pp. 15–17.

[10] See, for example, U. Aviram and S. P. Segal, "Exclusion of the Mentally Ill," *Archives of General Psychiatry*, Vol. 29 (1973), pp. 126–31; L. L. Bachrach, "A Note on Some Recent Studies of Released Mental Hospital Patients in the Community," *American Journal of Psychiatry*, Vol. 133 (1976), pp. 73–75; and Wolpert, Dear and Crawford, op. cit., footnote 2, especially pp. 27–31.

[11] See, for example, Wilfred A. Cassell, "Comparing Costs of Hospital and Community Care," *Hospital and Community Psychiatry*, Vol. 23 (1972), pp. 17–20; and D. M. Sheehan and J. Atkinson, "Comparative Costs of State Hospital and Community-based Inpatient Care in Texas," *Hospital and Community Psychiatry*, Vol. 25 (1974), pp. 242–44.

[12] Some of these ambiguities are discussed by J. B. Stubblebine and B. Decker, "Are Urban Mental Health Centers Worth It?" *American Journal of Psychiatry*, Vol. 127 (1971), pp. 908–12, and Vol. 128 (1971), pp. 480–83.

[13] For aspects of this debate, see the *British Medical Journal*, No. 6002, 17 January 1976, pp. 111–12; *Hospital and Community Psychiatry*, Vol. 25 (1974), pp. 383–401; and H. R. Lamb and V. Goertzel, "The Demise of the State Hospital—A Premature Obituary," *Archives of General Psychiatry*, Vol. 26 (1972), pp. 489–95.

[14] R. Clement, E. Ruch, and B. Sindon, "A Study of the Placement of the Psychiatric Patient," *Canada's Mental Health*, Vol. 24 (1976), pp. 17–19.

[15] Lamb and Goertzel, op. cit., footnote 8.

an institutional setting.[16] Smith also records a relatively low proportion (twenty-five percent) in institutions.[17]

Quite clearly, no simple generalizations about assignment expectations are possible. Cross-sectional analysis should, in any case, be treated cautiously (Table 2). The findings are strongly influenced by methodological considerations, such as the time elapsed between release and follow-up, the type of patient being studied, sample size, hospital expectations for the client, and aftercare provision.[18]

For this study, one of the most significant dimensions of the discharge program pertains to the spatial distribution of the discharged patients. This whole question received little systematic attention in the literature until the tendency for a minority of expatients to congregate in the transient areas of inner-city neighborhoods was noticed, more especially in United States cities. A potent factor in this "ghettoization" of the mentally disabled was the degree of community resistance to the location of mental health facilities in more stable residential neighborhoods.[19] As yet, few experiences of ghettoization have been reported in Canada, although there is no doubt of their existence, if only on a small scale.

In order to assess the impact of discharged patients in an urban area, a study was made of all persons discharged from Hamilton Psychiatric Hospital (HPH) for the first quarter of 1975. Our concern was to determine the impact of the discharge program, both in geographical terms, and in terms of patient disposition.

The most difficult methodological problem, common to all follow-up studies, is the task of actually tracking down the discharged patient. This is both an ethical question and a problem in detection.[20] In a survey of the situation of patients one year after discharge from psychiatric hospitalization, the Quebec Division of the Canadian Mental Health Association "lost" over seventy percent of their 903 person sample. The major categories of loss were patient refusal to participate (sixteen percent) and simple inability to contact the patient (twenty-nine percent).[21] Streiner et al. suggest that patient refusal to cooperate (especially if the patient identifies the research project with the hospital service) and transience of living arrangements are the two most important factors of sample attrition.[22] Studies by Strupp et al. and Michaux confirm these difficulties.[23] On the other hand, Lamb and Goertzel lost only 2 out of a cohort of 170 patients, and outstanding successes in follow-up are also reported in Langsley et al. and Meyers and Bean.[24]

The Daily Movement Charts, and the patient's Separation Record from HPH were used in order to obtain the following information for each patient: name, address, case number, discharge address, discharge disposition, and principal psychiatric diagnosis. A small group of mentally retarded patients, who were transferred directly to another hospital, was excluded from the sample. Ultimately, records for 239 patients discharged between January and March of 1975 were assembled. However, only 169 (seventy-one percent) were retained for anal-

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[16] M. Silverstein, *Psychiatric Aftercare: Planning for a Community Mental Health Service* (Philadelphia: University of Pennsylvania Press, 1968).

[17] Smith, op. cit., footnote 2.

[18] Representative survey experiences are to be found in F. A. Allodi and H. B. Kedward, "The Vanishing Chronic," *Canadian Journal of Public Health*, Vol. 29 (1973), pp. 279–84; J. Goodman, C. A. Woodward, and D. L. Streiner, "Wanted: A Tracking System for the Psychiatric Patient," paper presented at the National Conference on Evaluation in Alcohol, Drug Abuse and Mental Health Programs, Washington, D.C., 1974; and C. J. Smith, "Distance and the Location of Community Mental Health Facilities," *Economic Geography*, Vol. 52 (1976), pp. 181–91.

[19] Smith, op. cit., footnote 2; Wolpert, Dear, and Crawford, op. cit., footnote 2; and Dear, op. cit., footnote 4.

[20] Goodman, Woodward, and Streiner, op. cit., footnote 18, especially pp. 3–4.

[21] Quebec Division of the Canadian Mental Health Association, "A Survey of the Situation of Persons One Year After Discharge from Psychiatric Hospitalization," *Canada's Mental Health*, Vol. 23 (1975), pp. 14–15.

[22] D. L. Streiner, J. Goodman, and C. A. Woodward, "Correlates of the Hospitalization Decision: A Replicative Study," *Canadian Journal of Public Health*, Vol. 66 (1975), pp. 411–15.

[23] W. M. Michaux, *The First Year Out: Mental Patients after Hospitalization* (Baltimore: Johns Hopkins University Press, 1969); and H. H. Strupp, R. E. Fox, and K. Lesser, *Patients' Views of their Psychotherapy* (Baltimore: Johns Hopkins University Press, 1969).

[24] Lamb and Goertzel, op. cit., footnote 8; D. G. Langsley, M. Pavel, and K. Flomenhaft, "Avoiding Mental Hospital Admission: A Follow-up Study," *American Journal of Psychiatry*, Vol. 127 (1971), pp. 127–30; and J. Myers and L. Bean, *A Decade Later: A Follow-up of Social Class and Mental Illness* (New York: John Wiley, 1968).

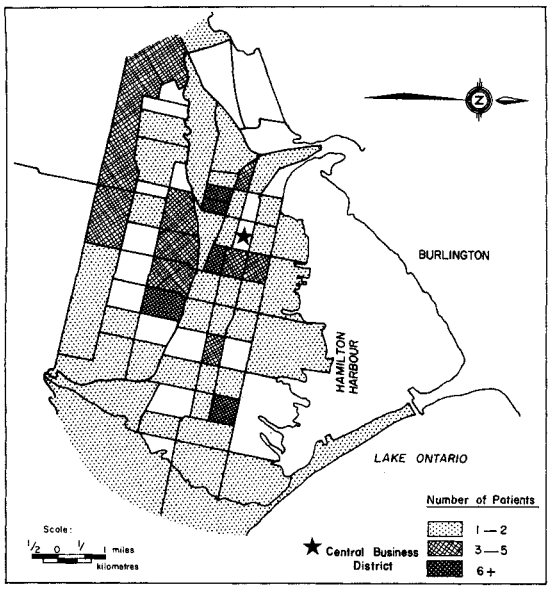

FIG. 1. Initial geographic disposition of the non-institutional component of the Hamilton Psychiatric Hospital discharge cohort (by census tract).

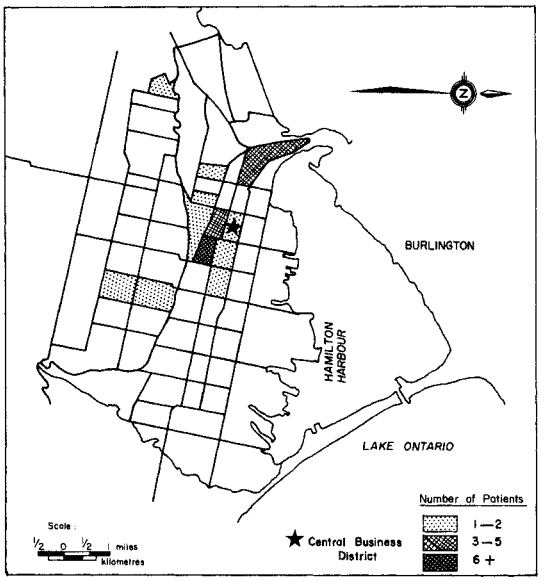

FIG. 2. Initial geographic disposition of the institutional component of the Hamilton Psychiatric Hospital discharge cohort (by census tract).

ysis since concern was with those patients who took up residence in the Hamilton region. Of the 169 patients, 142 took up residence in the city of Hamilton (sixty percent), thirteen reside in suburban areas just outside the city; and nine are involved in the criminal justice system. The remaining seventy patients reside elsewhere in Ontario.

The principal psychiatric diagnoses indicate that nearly sixty percent of the 169 patients had been in care for either schizophrenia or alcoholism. Significant proportions of affective psychoses and personality disorders were also evident, however. A wider comparison suggested that this discharge cohort is typical of HPH and provincial discharge patterns, both in terms of sex and diagnostic category.

Initial Disposition of Discharged Patients

The initial disposition of the discharge cohort indicates a relatively high proportion of noninstitutional arrangements. No less than 128 out of the 169 patients sampled (seventy-six percent) were referred either to family or to themselves (Table 2). Of the remainder, ten patients were referred to the courts, and twenty-nine (seventeen percent) to an institutional setting such as a nursing home, or a home for special care. The patients who are discharged into noninstitutional settings are relatively widely dispersed throughout the city of Hamilton (Fig. 1). There is, however, a concentration of discharged patients in the downtown area, and several tracts of higher expatient density near HPH itself. The former concentration may reflect the distribution of the population in need of care; it may also suggest the tendency toward ghettoization of expatients. The latter concentration supports the general distance-decay hypothesis that patients in need of care will reside close to the source of care.[25]

The distribution of the smaller total (twenty-nine) of institutionally-based patients shows a strong bias toward a downtown location (Fig. 2). As might be anticipated, the distribution of these patients is determined largely by the location of residential aftercare facilities, especially nursing homes and homes for special care. Since only 9 of the total sample of 169 patients could demonstrably be shown to be attending out-patient facilities after release, there is some doubt about the significance of this factor in the residential location behavior of the sample.

Follow-up Procedures

In order to assess the potential of the discharged patient group for filtering in an urban

[25] Further discussion of this hypothesis is to be found in M. Dear, "Locational Factors in the Demand for Mental Health Care," *Economic Geography*, Vol.

TABLE 3.—INITIAL AND FINAL PATIENT DISPOSITION OF THE HAMILTON PSYCHIATRIC HOSPITAL FOLLOW-UP SAMPLE

Disposition	Initial disposition (1)	Family (2)	Self (3)	Court (4)	Institutional			Not known (8)	Moved away (9)	HPH (10)	Lost (11)
					NH (5)	HSC (6)	Other (7)				
Family	74	68	1	0	0	0	1	0	1	0	3
Self	54	0	28	0	0	0	2	0	6	6	12
Court	10	1	2	3	0	0	0	0	0	0	4
Institutional											
NH[a]	16	0	0	0	15	0	0	0	0	1	0
HSC[b]	4	0	0	0	0	3	0	0	1	0	0
Other	9	1	3	0	0	0	2	0	1	0	2
Not Known	2	0	2	0	0	0	0	0	0	0	0
Final Disposition	169	70	36	3	15	3	5	0	9	7	21

[a] NH = Nursing Home.
[b] HSC = Home for Special Care.
Explanation: Column 1 of row 1 indicates that 74 patients were discharged initially into family care. Columns 2–11 indicate what happened to that 74, and so on.

space, a follow-up survey of the group was undertaken.

Since it was not intended to contact patients deliberately in the follow-up study, extensive use was made of alternative documentary evidence in order to confirm patient location. This evidence included the Separations card for residence and discharge addresses; the Hamilton City Directory, which includes data on residents at any given address; and the telephone directory. The discharged patients were grouped into three sets: those in family settings, where all sources confirmed patient location; those where sources conflicted, but follow-up residences were easily identifiable; and those where sources conflicted, and follow-up posed considerable problems.

For those patients whose discharge and residence addresses coincided, who were discharged to family, and who appeared in the City Directory or the telephone book, confirmation of address was relatively easy. Under the legitimate pretext of a university study in population mobility, the composition of a household was established. The aggregate evidence was sufficient to conclude that the patient resided at a particular address, although definitive verification of personal presence was not attempted. About one-third of all released patients were located in this manner.

For the second group of patients, the documentary sources either conflicted, or were only partial. Fortunately, many of these cases were located in boarding, nursing, and homes for special care throughout the city of Hamilton. In such instances, the purposes of the study were explained to the proprietors, and confirmation of patient residence is definite. It ought to be emphasized, however, that success in tracing this group is not so great as with the group one patients. This is because, with the exception of the elderly, most of the group two patients are not permanent residents at the homes. They are frequently released under their own recognizance, and often move between homes, or return to HPH.

The third group of patients was hard to find. Documentary evidence was scarce, and the patients often were discharged into the criminal justice system, or to no fixed address. In these instances, recourse was made to the patient's hospital casebook, but these typically contain little postdischarge data. Several patients were pursued through a sequence of two or three address changes.

Final Disposition of Discharged Patients

The follow-up survey was undertaken during July and August of 1975, between four and seven months since patient release. By the end of the survey, 148 out of the original 169 patients (eighty-eight percent) had been successfully located (Table 3). There was a general stability of the discharge cohort some six months after release because of the relative constancy of the family and institutional discharge group. During the survey period, however, a volatile minority (twenty-five percent) of the sample group moved on from their initial discharge.

53 (1977), pp. 223–40, and Smith, op. cit., footnote 18.

The most significant of this group are those discharged to self-care.

Of the 169 patients surveyed, 119 were found at their original discharge addresses; this is the sum of the entries on the main diagonal of the 7 × 7 submatrix formed by columns 2–8 (Table 3). A further thirteen patients moved within the four main disposition categories—family, self, court, and institutional; these are the figures off the main diagonal in the 7 × 7 matrix (Table 3). The remaining thirty-seven patients in the sample moved on to some entirely different disposition. Nine moved out of the region from their initial Hamilton address; seven returned to HPH (mainly schizophrenics, discharged to self-care in rental accommodations); and twenty-one patients were lost.

Some further comment on the lost patients is warranted, since they represent a significant minority of the total sample (twelve percent), and are probably typical of the "problem" patients who filter down into the transient, inner-city ghetto situation. Of the twenty-one patients lost, four were lost after release from the criminal justice system, ten dropped out of sight immediately, and seven were lost only after extensive search through successive inner city addresses. It is important to note that only three of the twenty-one lost patients were discharged to family care. The majority of losses were discharged to self-care. Typical of the hard core losses are patients who leave without notifying the landlord, or leaving a forwarding address, and who want nothing to do with HPH or aftercare. Those who were lost only after an extensive search were a motley crew—often alcoholic, and highly transient. As with the patients involved with the court, this group included several "revolving door" clients, who were probably destined to repeat the "hospital-court-release" cycle again.

CONCLUSIONS

The results reported in this paper enable some tentative conclusions to be drawn regarding the fate of psychiatric patients in the inner city. In this sample cohort, a significant proportion of discharged patients tended to congregate in geographically limited areas of the city, particularly the inner core. There seem to be two components in the ghettoization process. First, there is a formal assignment of patients to institutional aftercare facilities; these tend to proliferate in inner city locations.[26] Secondly, there is an informal process of spatial filtering encompassing the volatile minority of mobile patients who gravitate toward the transient inner areas of rental accommodation. Both components reinforce the geographical concentration of psychiatric patients.

It is significant that the geographical filtering of discharged patients is accompanied by a "sectoral filtering" of the same patients through various mental health care service categories. One abbreviated sequence, for example, involves the move from mental hospital, through another form of institutionalized aftercare, such as a foster home, to independent living in a downtown rooming house. It may thus be contended that the geographical trends noted in this paper are manifestations of the development of a new "asylum." The positive and negative aspects of the inner city asylum are only now being explored, but it is already evident that factors such as geographical proximity are of major significance in describing structure and function in the asylum.

The issues raised in this paper require urgent attention from researchers and policy analysts. In certain United States communities, the psychiatric patient ghetto is already being dismantled, largely as a consequence of community opposition.[27] Before further steps are taken to demolish a potentially positive community service modality, a full investigation of its impact on users and nonusers ought to be undertaken.[28] This would include consideration of patient viewpoints of the ghetto, and of the characteristics of the accepting or rejecting host community.

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[26] This is due, in part at least, to community resistance to psychiatric aftercare facilities in other neighborhoods.

[27] Wolpert, Dear, and Crawford, op. cit., footnote 2; and Wolpert and Wolpert, op. cit., footnote 6.

[28] Aspects of nonuser attitudes toward mental health facilities are considered in Dear, op. cit., footnote 4, and in M. Dear, R. Fincher, and L. Currie, "Measuring the External Effects of Public Programs," *Environment and Planning A*, Vol. 9 (1977), pp. 137–47.