A high proportion of the severely mentally disabled who used to reside in hospitals are now living in the cities; many have been placed there because of the availability of large old hotels and board and care homes; others have drifted there on their own. Still another contributing factor to the concentration of these patients in the cities may be the essentially urban nature of the deinstitutionalization model (Bachrach 1977); the architects of the deinstitutionalization movement have been, for the most part, urban in their residence and orientation. In any event, the result has been the clustering of thousands of expatients in the lower socioeconomic sections of our large urban areas.

In what kind of environments do these persons now find themselves? Much has been found wanting in our cities by urban planners and other students of contemporary American society (Schneider 1979). They have described such characteristics of our cities as a deepening social alienation which calcifies human behavior, promoted by the fractured nature of urban life. It is said that the biting lesson of human alienation in urban society is that the worthiness of individual existence is ultimately identical with the worthiness of interpersonal life, the very thing which has been neglected. The covering over of land by buildings and paving in our cities is seen as removing one from vital contacts with nature, a removal often unnoticed but rarely unfelt. In our desire to use time most productively, there is concern on the part of many that both time and speed can annihilate experience, that is, rob experience of reflection, inner organization, reformulation of thought and behavior, and, ultimately, human meaning.
While these are among the crucial problems of our time, paradoxically some of them work to the advantage of many of the severely disabled in their adjustment to the community. For instance, many long-term patients have great difficulty with interpersonal relationships and closeness and are able to "get lost" and escape interpersonal demands in the faceless society of our large cities. Further, in the cities, especially in neighborhoods which are not primarily residential, bizarre behavior and appearance are generally tolerated and often go unnoticed by passers-by. And for those who need a supportive network, Cohen and Sokolovsky (1978) have demonstrated that expatients can have meaningful and supportive social networks even in a large, single-room occupancy hotel in New York City. Their data suggest that these social networks, especially when they comprise involvement with other persons in the hotel, can act to reduce hospital readmissions.

There are other, perhaps more important, advantages of an urban environment for effecting the integration of exhospital patients into community life. Public transportation is better in urban areas, and confidentiality of patient treatment is much easier to maintain in the anonymity of the city (the clinic receptionist is less likely to be your next-door neighbor). Because there is a greater population to serve and draw from in the cities, there tends to be more, and a wider variety of, treatment and rehabilitation facilities, which makes for greater flexibility in formulating treatment plans; there also tends to be a greater availability of trained staff. The broad spectrum of different kinds of housing in the cities, both existing and potential, makes it easier to set up programs to meet the needs for varying kinds of living situations for the long-term mentally ill.

On the other hand, there are a number of negative factors that come into play when serving the long-term patient in an urban environment as compared to a more rural one. Urban areas tend to be high-crime areas which are more frightening to long-term patients, as well as to the rest of the citizenry. As a result, there is a heightened fear of going outside after dark, and it becomes more important for programs to schedule activities during daylight hours. There is increased exposure to street drugs, which becomes a major problem in trying to serve this population; it can be difficult to sort out the effects of drugs from the illness itself, and one now has an additional problem with which to deal. The long-term psychiatric patient is also vulnerable to hustlers and predators of all descriptions who abound in the cities (Reich 1972).