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Chapter 19

Disabling Cities

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Introduction

Geographic research on disability and cities is wide-ranging and encompasses the lives of people dealing with disability, physical impairment, and issues of mental ill health. This chapter focuses on what makes cities more and less disabling for persons with physical and mental health impairments whereby “disabling” refers to processes of physical and social exclusion arising from physical and social barriers to full participation in city life. It also engages with different ways of understanding disability (i.e., the medical, social, and embodied social models of disability) and the implications of these for whether and how cities need to change. A review of the literature on cities and disability serves to highlight a primary focus on issues of physical impairment and then is followed by an examination of processes shaping the lives of urban residents with mental health impairments.

A global South case study of Georgetown, Guyana, explores some of the ways in which this city disables persons with physical impairments. Since the vast majority (80 per cent) of people with disabilities live in the global South and because most of what we know about disability is based on research conducted in the global North, it is vital to learn more about disabling cities in the global South. This does not mean that valuable insights cannot be gained from studying disability and the city in the global North, and a second case study of visually impaired young people living in Liverpool, in northern England, explores how they

negotiate social space in the city and how the aids they use or choose not to use changes how they are treated by others. These two cities were chosen because of they are situated very differently in relations of power and oppression in the global order. Taken together, these case studies reveal that while social barriers to inclusion in city life such as poverty are especially severe in cities of the global South, this does not mean that disabled people do not face significant challenges in negotiating social space in cities of the global North. The Canadian context is introduced by an investigation of the use of urban space by persons experiencing mental ill health in the neighbourhood of Saint-Roch in Quebec City. This investigation reveals how such persons developed a space for support and social interaction in the Saint-Roch mall and how such spaces have been lost in the course of gentrification in the neighbourhood. This chapter argues that while cities in the global South and North continue to disable persons with physical and mental health impairments, it is important to recognize that disabled people, at least sometimes and in some places, find ways to resist these processes of marginalization in the city.

<1>Disability and the City

Before discussing how geographers and other urban scholars have researched disability and mental health in the city, it is helpful to chart the different terms used to understand disability.

<2>Words Matter: The Power of Definitions Framing the Debates about Disability in the City

This chapter is entitled “Disabling Cities” because it focuses on the experience of “disability” in the city. The words used to talk about disability have powerful meanings. Some, like

“lame,” “crippled,” or “handicapped,” are no longer used. Some words, like “impairment” or “deficit,” while used in medicine and health, are less often used in the social sciences. These terms map the different ways of thinking about disability: figures 19.1 and 19.2 show a medical model and a social model of disability.

[Insert Figures 19.1 and 19.2 here]

In the medical model of disability (Figure 19.1), disability is conceived as an individual’s impairment—the problem is with his/her/their body. The social model of disability conceives of disability very differently: it considers how disability comes from barriers in society that privilege some (able) bodies over others. Here, “the problem” is not the person, but a social world of place and attitudes that exclude people with disabilities. These two ways of thinking about disability are important for understanding disability in the city, as they lead to two very different pathways to change. For the medical model, it is up to individuals to overcome their impairment, while the social model demands that society becomes more inclusive and **accessible** (see Thomas, 2004, for more about definitions).

Geographers and other researchers have recently begun to think about a third way of thinking about disability, a **biopsychosocial model of disability** (Barnes and Mercer, 2010). This model takes parts of the medical model (individual lived experiences of minds and bodies) and the social model (structural or social barriers to participation) and puts them together with the understanding that disability is made up of a complex relation of factors that change over space and time (Worth, 2008). These different models of disability are important because they tell us how researchers have understood disability and the city (for reviews, see Hansen and Philo, 2007; and Imrie and Edwards, 2007).

Much work in geography and urban studies makes use of the biopsychosocial model, or of what some call an embodied social model of disability. Disability in this model is part of our identity (just like gender, ethnicity, and age), and discrimination on the basis of ability is called **ableism**. When assumptions are made about minds and bodies meeting an established norm and about anything other than this norm being problematic, this is ableism. Just like sexism or racism, ableism is a social phenomenon that values some bodies over others. In cities there are numerous examples of ableism; for example, the majority of public spaces, buildings, and transportation networks are built to suit an able-bodied user.

Examples of inaccessible (or ableist) urban spaces can be found everywhere—steps to access buildings or a lack of curb cuts, street furniture that impedes the travel of blind people, or a lack of induction loops in shops for the hearing impaired. Geographers have demonstrated that this is not an accident of urban planning, but rather an active process of exclusion: “Disability has distinct spatialities that work to exclude and oppress disabled people. Spaces are currently organised to keep disabled people ‘in their place’ and ‘written’ to convey to disabled people that they are ‘out of place’” (Kitchin, 1998: 351). For example, the French architect and urban planner Le Corbusier, an influential figure in modern urban design, explicitly stated that he designed buildings and public spaces for tall, strong, masculine, able-bodied, “ideal” bodies (Imrie, 1999). And in contemporary North America and Europe, accessibility legislation and building guidelines remain weak. Efforts have been made in the built environment to make spaces accessible to people with disabilities, by adding ramps or elevators or special assisted entrances—often to meet legislative minimums around accessibility—but even these attempts can powerfully mark disabled people as “out of place”—for example, disabled people might only be able to enter through a back door or with

an able-bodied person's help. Even though physical access is sometimes or is partially achieved, it is often without a sense of inclusion or equality.

The final important term to examine is **inclusive design**, a set of principles and practices that goes beyond functional accessibility and aims to create spaces that all users can use and feel comfortable in. Rather than treating disabled people as a separate group that needs to be planned for, inclusive design principles consider the wide diversity of human experience. For example, children and the elderly can have allied access needs, as well as parents with strollers or those who are temporarily injured. According to Imrie and Hall (2001), inclusive design offers a way of thinking through the “**social architecture**” that invades the built environment—ideas and beliefs about the design of our cities that have led to what our cities look like, who can use them, and how. Thinking critically about inclusion means challenging the **stigma** around disability and mental health and understanding that inclusion is about more than the physical design of a space, but also about how our social relationships play out across space.

<2>Geographers, Disability, and the City

Geographers' interests in disability and the city first emerged in the 1980s. Much of this early work was concerned with mental illness and related phenomena, such as community opposition to the siting of mental health facilities (also known as the “Not in My Backyard” syndrome—NIMBY). At this time, it was rare for geographers to consider how persons with physical impairments and ill health struggled to access and negotiate urban environments. One exception to this was Kirby, Bowlby, and Swann (1983), who, albeit briefly, considered the mobility issues faced by persons with physical impairments, including the elderly, in the

United Kingdom.

It was during the 1990s that geographers began to consider, in detail, how persons with chronic illness and physical impairment were disabled in the city. Isabel Dyck (1995, 1999) explores the shrinking **lifeworlds** of women with multiple sclerosis and the strategies they used to re-negotiate a disabled identity in the home, neighbourhood, and workplace. Valentine (1999) explores how physical impairment (spinal cord injury) diminished one man's access to urban places (such as the local pub) that were important in maintaining a working-class masculine identity. In his wide-ranging historical materialist study of disability, Gleeson (1999b) shows how the rise of industrial capitalist cities in the nineteenth century was accompanied by the growing segregation and exclusion of disabled people (e.g., in asylums). He also examines disability and contemporary cities, arguing, for example, that the provision of "community care" was insufficient to ensure that disabled people's rights to fully participate in urban life were realized. Gleeson (1999a) also addresses the question of whether technological innovations (e.g., in **assistive devices**) can overcome the disabling city. He concludes that technology alone cannot "cure" disability or rehabilitate physically impaired bodies. What is needed, he argues, is political-economic, institutional, and cultural change in the forces shaping today's cities so that disabled people's aspirations for a valued place in urban society can be realized. This could include greater access to paid employment and a cultural shift away from regarding persons with impairments as "lesser" in favour of simply being different.

Geographers have also considered how architects' visions of the city and the bodies that move through it have shaped the built environment. As noted above, Imrie (1999) reveals how Le Corbusier envisioned the city as the domain of male able-bodied people and designed the

built environment to cater to this ideal or norm of what a city dweller is (e.g., buildings with steps; housing that is inaccessible to wheelchair users). Kitchin (2003) criticizes the architectural profession in Ireland for failing to design accessible urban environments. He argues that access should not be sacrificed because of concerns over such things as cost or aesthetics. Kitchin and Law (2001) point out that design professionals, including urban planners, have failed to ensure that there are accessible public toilets in Irish cities and have thus hindered disabled people's ability to fully participate in urban life. Geographers have also written about the principles and practices of inclusive design as a means of creating more accessible urban environments (Imrie and Hall, 2001).

Geographers' work on disability and the city during the 1990s included efforts to challenge tendencies to assume that disabled people were passive subjects of oppression. Hester Parr (1999), for example, in her study of psychiatric service users in Nottingham, documents instances of resistance to dominant medical treatment practices (e.g., using herbal remedies). Chouinard (1999) discusses disabled women's activism in Canadian cities and internationally, noting that much of the history and geography of it remains to be written.

In the twenty-first century, there have been signs of both continuity and change in geographers' approaches to understanding disability and the city. One sign of continuity is an ongoing interest in disabled people's experiences of marginalization and inclusion in different workplaces. Hall and Wilton (2011), for example, explore the potential of unionized mainstream workplaces, alternative social enterprises, and the arts to provide supportive "working" environments for disabled people. Chouinard (2011) reflects on how university workplaces disable persons with physical and mental health impairments, drawing on her own experiences as a disabled female professor. There has also been ongoing interest in how

chronic illness reshapes lives and alters the meanings assigned to places such as the home (Crooks, 2010).

There have also been important signs of change in how geographers understand disability and the city. One such change is a more expansive understanding of disability and the kinds of embodied differences that can be disabling. Longhurst (2010), for example, explores how women who are large or “fat” are disabled in terms of the material environment (e.g., seats and changing rooms that are too small) and also emotionally (e.g., loathing the size difference they embody). People who are of short stature also face challenges. Kruse (2010) reveals that “little people” adapt or “restaturize” private spaces of the home to make them more enabling than the public spaces they have to negotiate. Davidson (2003) helps to put phobias and conditions such as autism (e.g., Davidson and Parr, 2010) on the agenda of geographers concerned with disability and the city. Geographers have also demonstrated an interest in how addiction treatment programs are negotiated in more and less enabling ways. Men with addictions, as Wilton et al. (2014) show, rework their masculine identity in the process of recovery—learning, for example, to be less aggressive in their behaviour, to share their emotions with others, to recognize their interdependence with others (cf. buying into the notion of the independent man), and to no longer associate practices such as drinking alcohol with being a “man.”

Geographers’ approaches to disability and the city have also become more expansive in terms of the types of interactive spaces that are considered. In particular, there has been growing interest in online interactions in the virtual space of the Internet among groups such as people with mental health impairments, autism, and hearing impairments (Skelton and Valentine, 2010). Findings suggest (as textual interactions are more in line with autistic

communication practices) that persons with mental health challenges may find interactions in virtual space enabling in some ways (e.g., in terms of access to information and support) but disabling in others (e.g., when the emotional support demanded of them by other users is experienced as excessive) (Davidson and Parr, 2010).

Almost all of what geographers know about disability and the city is based on research conducted in the global North. Yet the vast majority of disabled people live in the global South. It is important, therefore, that geographers learn more about disability and cities in the global South. Chouinard's (2012, 2014, 2015) work, including the case study of Georgetown, Guyana, in this chapter, begins to address this enormous gap in our understanding of disability and the city. The term "disabled people" is used in this chapter to emphasize, as in the British disability studies tradition, that it is society that disables persons with impairments (as such, it is preferable to the term "people with disabilities" usually used in the North American context).

<2>*Mental Health and the City*

Understanding the "disabling" actions of the city is incomplete unless attention is also paid to the multiple ways in which city life affects mental and emotional well-being and to how city spaces can be disabling or enabling with regard to mental and emotional well-being.

Researchers' attention has been directed at how cities foster accessibility, possibilities for inclusion, or, conversely, marginalization and exclusion for people experiencing different types and degrees of emotional distress or madness. It is also important to recognize how city life itself can heighten mental states.

The different terms used to talk about mental states—distress, illness, madness—serve to illustrate the degree of disagreement over terminology—what Parr and Philo (1995: 207) call the “vexed issue of what this thing we call ‘madness’ actually is.” Indeed, the different terms used to discuss madness evoke diverging ideologies through which experiences of mental and emotional difference and/or un-wellness are understood and explained. Thus, the expression “mental illness” usually refers to a medical perspective implying institutional processes of treatment and diagnosis (refer back to Figure 19.1), whereas thinking in terms of mental and/or emotional distress may encompass a wider range of experiences of emotional un-wellness that are not necessarily officially diagnosed and that can be episodic. The terms “madness” and “mad” are used not only to establish a distance from a sole concentration on **medico-psychiatric models of mental illness**, but also to encompass an unlimited range of experiences of mental and emotional distress—for example, from mild depression to major depressive disorders (Mullings and Peake, forthcoming). Moreover, the terms “mad” and “madness,” if they have been long considered negatively, are now being reappropriated by communities of mental health services users (see, for example, Mad Pride Toronto, 2014).

Much like physical illnesses and/or disabilities, experiences of mental distress are intertwined in particular experiences of space that can be constraining and/or exclusionary. Mental and/or emotional distress, in this sense, challenges the conceptual opposition between mind and body by highlighting that, on the one hand, experiences of exclusion and/or difference are embodied—that is, they are lived through the body—and on the other hand, that the ways in which we experience our bodies are shaped by our personal social histories and geographies, including those of exclusion and/or difference. Parr and Philo (1995), for example, discuss how different discourses associated with different types of city spaces

(institutional, semi-institutional, and non-institutional) are mobilized by users of mental health services in their construction of complex and sometimes contradictory subjectivities as ill individuals. Moreover, in a very practical sense, mental and emotional distress and/or illness translate into bodily traits, such as particular movements, appearances, reflexes, displays of emotion, and behaviours (Wolch and Philo, 2000). Thus, states of mental and physical illness together shape individual social experiences (Parr, 2008).

It is no surprise then that geographers' interests in disability and the city first developed in the 1980s around community attitudes towards the mentally ill and mental health facilities (see Taylor and Dear, 1981). In 1987, Dear and Wolch published their landmark study entitled *Landscapes of Despair: From Deinstitutionalization to Homelessness*. In this book they linked processes of urban change such as **deinstitutionalization**, the spatial concentration of community mental health facilities in poorer inner-city neighbourhoods, **gentrification**, and the loss of affordable housing to the growing phenomenon of **homelessness** in cities in Canada and the United States. Across the Atlantic Ocean, in the United Kingdom, Chris Philo (1987) had started to write about the development of urban and rural asylums for the mentally ill in the nineteenth century.

Mental illness was constructed, and became widely understood, as a medical dysfunction during the rapid industrialization of Western cities. As a medicalized condition, the treatment of mental illness involved isolation from the “sane” population and movement into residential institutions—“lunatic” asylums—that were generally located outside of the city. The second half of the twentieth century saw increasing protests against the institutionalization of the mentally ill that, combined with developments in medication allowing for an improved management of certain psychiatric conditions (such as

schizophrenia), resulted in large-scale waves of deinstitutionalization from the 1960s onwards.

Deinstitutionalization implied that former inmates were returned to community life and directed towards local mental health services for the provision of mental and social care. It also implied a concentration of mental health service users in inner-city areas, as they followed the location and availability of community services and housing. This meant the development of **post-asylum geographies** through which mental distress quickly became a significant element in the geographies of cities (Wolch and Philo, 2000).

Geographers have been interested in processes of inclusion, exclusion, and marginalization of individuals experiencing mental distress in cities following deinstitutionalization. They have investigated the distribution, location, and access of care and support services (Wolch and Philo, 2000). Of particular interest has been the development of “psychiatric ghettos,” which refers to the phenomena of a positive feedback loop through which small-scale mental health centres and housing facilities, as well as populations of mental health services users, became concentrated in a relatively small areas (Wong and Stanhope, 2009). Related to this “ghettoization” of mental health services users, geographers have also investigated processes of “drift,” that is, the movements of deinstitutionalized or never-institutionalized users through the city following the changing distribution of medical and social care services (Wolch and Philo, 2000).

Post-asylum geographies are also characterized by a particularly virulently stigmatized type of difference (Dear and Wilton, 1997; Parr, 2008). Stigma, an important concept in the geographies of mental distress, refers to particular negative ways of constructing and understanding differences. Stigma occurs when traits are identified and associated with

undesirable characteristics (stereotypes) and are used to categorize individuals as belonging to a separate group—“them” versus “us,” the “mad” versus the “sane.” The persons thus labeled experience loss in status and several processes of discrimination and exclusion (Link et al., 2004). The importance of stigma in the lives of individuals experiencing mental distress has led geographers to investigate spatial processes of ostracization—in other words, how mental distress and/or illness is socially articulated as “other,” as deviant, and as dangerous—and the practical implications of this ostracization in the day-to-day geographies of urban mental distress.

One phenomenon thus highlighted is the impact of local community mobilization against the establishment of mental health services sites—such as drop-ins, rooming houses, or day centres—in particular neighbourhoods, a phenomenon referred to earlier in the chapter as NIMBY. Geographers have found that NIMBY reactions are especially present in suburban and family-oriented affluent areas, thus contributing to the concentration of mental health services and spaces associated with mental distress in poorer inner-city neighbourhoods (Wilton, 2000).

Alternatively, geographers have been interested in processes or structures that make city spaces more enabling for persons experiencing mental distress. Parr (2008), for example, argues that the “nature work” or gardening done in cities has the potential to promote greater inclusion of persons with mental distress. In particular, she cites the example of the Coach House project in Glasgow, which by creating more aesthetically pleasing public spaces through gardening and other activities, has encouraged surrounding residents to value the work done by persons with mental health impairments.

Geographers are also increasingly concerned with the relationship between neoliberal social and economic policies, financial precarity, and mental distress. The shift towards neoliberal paradigms and models of governance of the last decades throughout the global North has often involved drastic cutbacks in the services and programs used by individuals experiencing mental illness, from access to psychiatric care to government financial assistance (Wilton, 2004). Like canaries in the mine, individuals experiencing mental distress, already proportionally poorer and more vulnerable, are among the first to suffer from the dismantling of social safety nets.

The precarity of individuals struggling with mental distress is often related to isolation and difficulties in maintaining regular employment (among other things), which in turn can contribute to a compromised sense of emotional well-being (Wilton, 2004). This translates in a high proportion of people struggling with mental distress relying heavily on government transfers and services for their income (through various social assistance and disability programs) and their housing (e.g., in subsidized rooming houses). Following major cuts in government funding, the increased poverty of mentally ill people has led to new and/or intensified forms of stigma in which stereotypes and emotional reactions associated with mental distress and/or illness combine with those associated with the poor—for example, when limited resources lead individuals to wear clothing that is considered socially undesirable or even inappropriate, marking them as both mad and poor.

Poverty in turn increases both the amount and the steepness of barriers preventing individuals experiencing mental distress from participating in a “normal” social life and urban spaces. Neoliberal cities are characterized by the rarity or absence of open public spaces and the dominance of spaces centred on consumption. Hence, spaces of open and/or cheap

consumption, such as malls and fast food restaurants, often play a critical role in the daily geographies of mentally distressed individuals, particularly those who are poor. They are open longer and more regularly than centres specifically designed to offer mental health care services—and are often much more accessible. Their importance in the lives of individuals experiencing mental distress is symptomatic of the scarcity of mental health care services and of the privatization and marketization of public urban spaces. The inability, or limited ability, to engage in consumption—for example, buying oneself a coffee—in such places enhances experiences of “out-of-placeness” and exclusion (Knowles, 2000).

Poverty can also limit the ability of individuals struggling with mental distress to conform to basic norms of social inclusion, such as maintaining certain standards of personal care and hygiene and regular housing. In urban settings, issues of mental illness and homelessness are inextricably tied to one another, as on the one hand individuals experiencing mental health issues are more likely to be under-housed or homeless and on the other homelessness, with the associated experiences of intense stress and precarity, can in itself trigger and constitute forms of mental distress.

Neoliberal times are characterized by *both* intensified poverty and exclusion *and* a dominant discourse on the personal responsibility and moral obligation to conform to a norm of economic self-sufficiency. This implies that the associated stigma of mental illness and poverty increasingly leads to experiences and articulations of mental illness as deviancy, threat, and criminality (McGrath and Reavey, 2015; Parr, 1999). It is thus argued that we are currently experiencing a shift in geographies of mental distress from community services back to institutionalization, namely in the shape of the prison system. Meanwhile, contemporary stressors associated with enhanced competition and financial precarity have been associated

with increasing rates of mental distress (Sedghi, 2015). Thus it may be that while the mentally ill and/or distressed are being increasingly marginalized and excluded, mental distress is quickly becoming an increasingly common experience. The two case studies that follow from Georgetown, Guyana, and Liverpool, England, explore some of the key social barriers that serve to disable people with impairments.

<1>Social Barriers to Disabled People’s Inclusion in City Life: Georgetown, Guyana

Georgetown is the capital city of Guyana. It is also the country’s largest urban centre. According to the 2015 census, the metropolitan city was home to 335,000 people (World Population Review, 2015). Georgetown is located on the coast of the Atlantic Ocean at the mouth of the Demerara River and is the main port for the country. It also serves as a retail, administrative, and financial services centre. The city is protected from high tides by a seawall (it lies five feet below high-tide levels). Owing to the risk of flooding, many older buildings were originally erected on wooden or brick stilts—making them inaccessible to many persons with physical impairments. Today many of the spaces below these buildings have been filled in and put to use (Figure 19.3).

[Insert Figure 19.3 here]

This case study draws on results from 60 interviews with disabled people and 10 interviews with disability activists and service providers in Georgetown, Guyana, South America (Chouinard, 2012). Disabled people are generally acknowledged as being among the “poorest of the world’s poor,” but the poverty that disabled people face in a global South nation such as Guyana is especially severe. The vast majority of disabled people interviewed struggle to survive on less than one US dollar per day (the equivalent of approximately \$200

Guyana dollars). Poverty acts as a social barrier to inclusion in the life of the city and makes it difficult for disabled people to participate in organizing around disability issues. Disability activists comment on how disability organizations have experienced dwindling membership because people cannot afford the cost of transportation to meetings. Very impoverished living conditions also mean that it is difficult for activists to get disabled people out to rallies in Georgetown—and activists see this as a significant barrier to encouraging government action on disability issues. Poverty also limits disabled people’s capacities to access health care and to maintain their health (e.g., because of difficulty affording travel to places offering health care and necessities such as medication or nutritious food). The disabled women and men interviewed adopt a variety of strategies to try to augment their incomes. Some beg for food and money and others do odd jobs such as tiling. Kim, a physically impaired wheelchair user knits chair-backs to sell. Like some of the other disabled people interviewed, however, she finds that people wanted to pay her less for them because she is visibly impaired. Mary, a visually impaired woman, sells small items such as packets of powdered drinks to augment her income. Mary also sometimes receives money from a relative living abroad (remittances), but this is an unreliable source of income for her.

Violence, particularly male violence against women, is a cause of impairment for some of the women interviewed. And the fact of having been impaired through “chopping violence” (i.e., the use of a cutlass to kill or maim women) in some cases has become a basis for blaming women for the violence they experience. Marta, a woman who lives on the outskirts of Georgetown, lost both forearms to chopping violence carried out by her male partner. Unfortunately, she has found that some people tend to blame her for the violence she experienced (e.g., they argue that she deserved it for being “promiscuous”) and that others in

her community, as well as members of her family, shun or avoid her as a result. This has limited her opportunities to participate in the life of the city. It is worth noting that contemporary experiences of chopping violence reflect the continued use of cutlasses to harvest sugar cane and a violent colonial past in which black slaves and later indentured servants from India were forced to labour on sugar plantations.

There are also cultural barriers to disabled people's inclusion in life in Georgetown. These barriers include practices such as shutting disabled family members in the home and thus rendering them invisible in public spaces of the city. This invisibility, activists argued, is an important barrier to convincing government officials to act on disability issues. Cultural attitudes that devalued disabled people are also barriers to inclusion and well-being in the city. Lawrence, a man physically impaired by a stroke, related how people in his neighbourhood would call him derogatory names such as "stink nasty" when he was out in public. This name-calling was a way of devaluing his presence in the city and left him feeling isolated and alone.

Some of the barriers to inclusion and well-being in the city are both economic and cultural in nature. Private mini-bus drivers, for example, frequently fail to pick up passengers who use wheelchairs or other mobility aids. This is because doing so diminishes the number of fares that can be collected (because of space taken up by mobility aids) and also reflects the common practice of devaluing visibly disabled people. This problem was sufficiently widespread to trigger a (largely unsuccessful) "right to ride" campaign.

The out-migration of trained medical technicians to countries in the global North and constraints on state funding (e.g., to train replacement workers) have meant that women such as Marta lack access to prosthetic aids that could enable them to more fully participate in life in Georgetown. In Marta's case, a foreign-aid agency provided very basic prosthetic arms on

a one-time basis. This, as well as a shortage of prosthetic technicians in the city, meant that when the arms broke they were not repaired and Marta was left without them.

Disabled people in Georgetown face many other barriers to inclusion and well-being in city life. For example, workers who are visibly impaired are paid lower wages than other workers, and disabled family members who are shut in the home are made to feel that there is something “shameful” about being visible in public. The poverty in which so many of them live is especially severe and reflects Guyana’s marginalized place in the global capitalist order. So also does the out-migration of trained health professionals and the scarcity of technicians trained to make and fit prosthetic arms or legs. While this case study suggests that social barriers to inclusion in city life are especially severe for disabled people in the global South, disabled people still face significant challenges in negotiating the social space of the city in the global North. The next case study, of visually impaired young people in Liverpool, examines the strategies they use to move about the city and to have their embodied presence read in particular ways by others (e.g., as “independent”).

<1>Young People Negotiating Visual Impairment in Liverpool

This case study examines the experiences of visually impaired (VI) young people living in the city of Liverpool. Liverpool is a large coastal city in the northwest of the United Kingdom. Formerly known for the economic activities associated with its port, the city now focuses on aspects of the service sector, including tourism and the knowledge economy. The downtown features many pedestrianized shopping streets close to the main train station, Liverpool Lime Street, with museums and tourist attractions close by in the refurbished Albert Docks (Figure 19.4).

Despite the walkability of the city, for many people with disabilities, going about their everyday lives in cities like Liverpool can expose them to harassment, condescension, or just the uncomfortable feeling of being on display (Morris, 1991). For disabled young people who want to be seen as independent, negative social attitudes about their disability can be especially challenging. Moreover, while disability often makes us think of physical impairment, the focus on sensory impairment in this case study and on mental health in the Canadian text box (see below) demonstrates that mind-body differences are diverse. Rather than asking VI young people how they physically navigate the city, Worth (2013), in this case study, explores how VI young people negotiate the social space of the city—a space that can often feel unwelcoming. Young people use a variety of strategies to get around the city; some use white canes, some use a guide dog, and some rely on their friends to get out and about. Critically, the choice and use of different mobility aids—or mobility strategies—also changes how visually impaired young people are treated in public space.

[Insert Figure 19.4 here]

Will is partially sighted and is comfortable getting around on his own. When city streets become crowded and he loses his landmarks, he pulls a symbol cane out of his backpack—this signifier of visual impairment means that people back up and give him space, but it also marks him out as “different,” so Will only uses it when he has to (Figure 19.5). James is blind, and is very comfortable navigating the city on his own, using a cane. When people assume he needs help, rather than be upset that his independence is not recognized, James accepts help he does not need, explaining that “there might be somebody else two weeks later that struggles to cross roads and they’d like somebody to offer them their hand. Like it doesn’t really bother me, but it’s always kind of a thing not to put people off” (Worth, 2013: 581).

While this is a kind reaction to a gesture that was kindly meant, it demonstrates how James's capabilities are made invisible by his blindness. For Willow, having a guide dog is useful in several ways—primarily her dog helps her get around town by herself—but it also has an important social function for her. People she meets on the street, in a café, or on the train to college chat with her about her dog rather than treat her like she was strange or weird. Having a guide dog is a good ice-breaker and helps to create a friendly atmosphere that she values. Finally, Sarah finds that dealing with insults or rude questions as a blind girl in public space is often a difficult experience. Her solution is to travel with her friends rather than on her own, linking arms with her mates rather than using a white cane or a guide dog. She explains:

<BLOCK QUOTE>

I don't like the look of [a cane] and I don't like the fact that it makes you, it brings you more attention than other people. And people know straight off that you're a bit "spesh" [special], if you get me. . . . I don't want to be the odd one out. . . . I don't really see the benefit. I just think you get bullied, and I'd rather not to be fair. I'd rather trip over a piece of paper than get bullied for being special. (Worth, 2013: 579)

Much to the regret of her parents and her teachers, Sarah is willing to sacrifice her own independence to be more anonymous in public space. Her experience shows how important the social is to a conception of disabling cities.

[Insert Figure 19.5 here]

For Will, James, Willow, and Sarah, how they get around the city is not a question of physical accessibility, although they live in an urban environment with very few features for

blind people. (Accessible public spaces for VI people include features such as audible crosswalks that beep during the walk signal, tactical bumps along curb cuts so that VI people know they are entering a roadway, and uncluttered sidewalks). In contrast to the experiences of disabled people in Guyana, for the VI young people involved in this research, the inaccessibility of the built environment is a difficulty that they manage or just get on with. In contrast, dealing with people's reactions to their presence in public space is a much bigger negotiation: it is often very difficult to be recognized as a competent spatial actor because of the negative impact of ableism.

The following section moves to a Canadian context, addressing the state of mental health care funding and service provision in Canadian cities, with particular reference to Quebec City, and reiterating this case study's focus on the city as an often unwelcoming social space.

<1>Text Box: Disabling Cities in Canada and the Mail Saint-Roch in Quebec City

Emotional and mental instability is a common trait in Canadian lives. Twenty per cent of Canadians will personally experience mental illness in their lifetime, and in this way mental illness affects all Canadian lives, at least indirectly, be it through a family member, a friend, or a colleague (CMHA, 2015). As well, emotional and mental instability represents an important area of government spending in Canada: by 2000 the economic cost nation-wide of mental illnesses to the health care system was estimated to be at least \$7.9 billion in 1998—\$4.7 billion in care, and \$3.2 billion in disability and early death. Moreover an additional \$6.3 billion was spent on uninsured mental health services and time off work for depression and distress that was not treated by the health care system (CMHA, 2015).

Despite its prevalence, emotional and mental instability tends to remain socially unrecognized. For example, although approximately 8 per cent of Canadian adults will experience major depression at some time in their lives, about half of those who feel they have suffered from anxiety or depression will never seek medical help (CMHA, 2015). As discussed above, the stigma attached to such experiences presents an important challenge to inclusion into community lives.

In Canada, a large proportion of individuals experiencing mental distress live in poverty and in unstable housing situations (Nelson et al., 2015). As in most of the global North, massive waves of deinstitutionalization occurred throughout Canada starting in the 1960s, leading to concentrations of individuals with mental illnesses in service-dependent neighbourhoods. Vancouver's Downtown Eastside (Boyd and Kerr, 2015), Toronto's South Parkdale (Slater, 2004), Montreal's Downtown and Centre-Sud (Knowles, 2000), and Quebec City's St-Roch (as discussed below) are examples of such neighbourhoods. They are characterized by a relative concentration of mental health community services, and—importantly—by comparatively affordable housing options, such as boarding homes, rooming houses, and blocks of bachelorette apartments (Slater, 2004; Boyd and Kerr, 2015).

In these neighbourhoods, the lives of individuals experiencing mental distress weave particular geographies characterized by constant movements between institutional, semi-institutional, and non-institutional places (Parr and Philo, 1995). The latter comprise places where access is relatively open and cheap, such as streets, churches, malls, and fast-food restaurants (Knowles, 2000). The presence of mentally distraught individuals in such places of consumption, which are increasingly replacing open public spaces in Canadian cities, is heavily controlled and repressed by police forces—a circumstance that often leads to

additional trauma and strain on these individuals' mental health (Boyd and Kerr, 2015). This heavy policing feeds and is fueled by ideological discourses associating mental illness and poverty with insalubrity, criminality, and violence. In their study of police perception of individuals experiencing mental distress in Vancouver's Downtown Eastside, Boyd and Kerr (2015) demonstrate that such discourses, while feeding general moral panic, promote practices that lead to greater insecurity and exclusion for individuals in the neighbourhood experiencing mental distress.

In a similar vein, Slater (2004) argues that discourses linking mental health issues, single occupancy, criminality, and insalubrity were foundational in gentrification efforts in South Parkdale in Toronto. From the 1950s and 1960s, South Parkdale experienced a series of changes, including the construction of the Gardiner Expressway and the resulting destruction of hundreds of houses; the exodus of the middle and upper class to other urban neighbourhoods or suburbs; and the massive waves of patients discharged from the Queen Street Centre for Addiction and Mental Health, for a long time the largest facility of its kind in Canada and located in the neighbourhood (Slater, 2004). Since the mid-1980s, the city of Toronto has led gentrification efforts in South Parkdale, specifically by tightening regulations around single-occupancy accommodations. The resulting closure of rooming houses and bachelorette blocks, while making way for other types of dwelling targeted at families and higher-income individuals, effectively expelled individuals who relied on cheaper accommodation options from the neighborhood. Thus, Slater (2004) argues that the emancipatory action of gentrification, as advocated by the city, must be critically questioned in terms of inclusion and exclusion.

The Saint-Roch Mall, located in downtown Quebec City, is another telling example of a consumption-oriented space whose history, from its construction to its dismantlement, is closely intertwined with histories of neighbourhood changes, urban imaginings, and movements of people experiencing mental and emotional distress (Figure 19.6). The Saint-Roch neighbourhood is centrally located and was once an economic pivot of Quebec City. The decline of the neighbourhood, initiated during the Great Depression in 1929, accelerated in the 1960s with the rise of suburban lifestyles, the increasing importance of the automobile, and the development of shopping centres with convenient parking facilities. By the 1970s, Saint-Roch had experienced a massive exodus of both people and commercial operations. In an attempt to counter this trend, store owners embarked on a venture to put a covering over Saint-Joseph Street, the local commercial artery, in order to create an indoor mall.

[Insert Figure 19.6 here]

However, the development of the Mall Saint-Roch failed in its economic objective and the neighbourhood continued to be increasingly associated with poverty, crime, and marginality. In 2000 the mean household income in Saint-Roch was \$18,537, less than half the city's median. Today, approximately half the neighbourhood's population live under the poverty line. Saint-Roch residents have poorer health and live shorter lives than the average Quebec City resident (Centre de santé et de services sociaux de la Vieille-Capitale, 2011). In this context, the mall, rather than rekindling local commercial vitality, soon became a haunt for the local poor, including the homeless, the elderly, and individuals experiencing mental distress (Freedman, 2011).

At the same time, the province of Quebec experienced two large waves of deinstitutionalization of mental health care, first in the 1960s and then in the 1970s–1980s.

Saint-Roch became an important crossroad for the newly deinstitutionalized patients, thanks in part to the proximity of local mental health service centres. The real estate values in the neighbourhood were lower than in more prosperous areas, and landlords were somewhat more willing to accept individuals experiencing mental health issues, which led to a local concentration of rooming houses. Thus, following deinstitutionalization, about half the individuals with mental health issues in Quebec City congregated in Saint-Roch. These individuals were generally poor, with 57 per cent of them having a yearly income under CAD\$12,000 (Centre de santé et de services sociaux de la Vieille-Capitale, 2011). An underground and exploitative industry flourished around these individuals, involving pawning, cashing welfare checks for a fee, and usury. An important proportion of these individuals also experienced some forms and periods of homelessness.

Lives of deinstitutionalized mentally distraught individuals, particularly those who are homeless, are characterized by unrest and mobility as they navigate networks of resources to meet their basic needs and to socialize on a daily basis. The Mail Saint-Roch represented an anchor in many urban nomadic lives. Designed to foster leisurely consumption, the mall was a place where individuals could loiter while remaining warm and dry and freely access basic resources such as drinking water and washrooms. The mall was also an important place of congregation where individuals with mental health issues would socialize with one another, as well as with other local poor people, especially the elderly (Bourgeois, 2008; Freedman, 2011).

The progressive closure of the mall over the early 2000s meant the loss of a shelter, a landmark, and a central organizing feature in the lives of the Saint-Roch residents, particularly those experiencing mental distress. The dismantlement of the roof over Saint-Joseph Street

was part of a wider trend to revitalize Quebec City's downtown and rekindle its attractiveness as both an upscale commercial and a residential area. It involved a process of dilution (Parazelli et al., 2013) meant to break off the concentration of spaces and resources used by mental health services users and the homeless.

Despite the creation of alternative spaces and services, the dismantlement of the mall further marginalized mentally distraught individuals in Saint-Roch by increasing the length and frequency of their movements through the city as they followed the dispersion of resources such as drop-ins or food banks over a wider territory. This nomadism and sense of rootlessness in their lives are enhanced by the increased surveillance and control of public spaces and by the criminalization of "mad" behaviours, such as sleeping on public benches or talking and/or yelling to oneself and/or to passers by, that are included in the gentrification efforts in the neighbourhood (Bourgeois, 2008; Freedman, 2011).

<1>Conclusion

This chapter has examined disability in the city, beginning with definitions of disability and the medical, social, and embodied social models of disability as well as of inclusive design. The chapter then examined work by disability geographers, tracing important trends from early work on mental health to the rise of the subfield of disability geography in the 1990s. Recent work on disability has expanded to include more forms of bodily difference, challenging stereotypes about which bodies are "normal." Next, the chapter's focus shifted to mental health/distress in the city, noticing the reclaiming of the term "mad" and highlighting the inherent connections between mind and body. Weaving geographic literature on mental health into a history of asylums, deinstitutionalization, community living, and NIMBYism, the

section emphasized the destructive power of stigma. The case studies examined disability in the city from two perspectives. The first explored the intersection of poverty and disability in Georgetown, Guyana, where an inaccessible built environment and negative cultural attitudes often discourage disabled people from being in public space and taking part in city life. The next case study, on visually impaired young people in Liverpool, UK, also considered the importance of social inclusion in the city. Even though a space may be physically accessible and disabled people can navigate it, it may still be exclusionary because of the sometimes negative reactions of the public. In the Canadian context, the theme of social inclusion was explored, specifically the intersection of urban poverty and deinstitutionalization through the Mail Saint-Roch in Quebec City. The gentrification of the neighbourhood and the closure of the mall illustrate how cultural attitudes and ableist day-to-day social interactions with people with disabilities and mental health conditions become implicated in city planning.

While research on disability and the city is slowly moving forward in the global North, there remains much work to be done in the global South, where most disabled people live and where hardships can be acute. Just as work needs to be done with different members of disability communities to help us understand their urban experiences, there is a need for research in cities around the world to capture local cultures and show how disability is lived in diverse places. There are three thematic areas where research on disabling cities can be taken forward. The first concerns interrogating the built form of the city, as physically inaccessible spaces undermine other attempts at inclusion. The second future area of work involves scaling up some of the in-depth, qualitative work that is popular in the subfield of disability geography—examining and critiquing policies and practices of exclusion in the city. Finally, in researching the urban more generally, geographers often pay attention to gender,

ethnicity, and socio-economic status, yet other forms of difference—especially disability—are unmentioned. Fully understanding citizens and urban life ideally involves embracing the complexity of our identities—disability and mental health are important parts of this intersectional picture.

<1>Key Points

- How disabilities are conceived influences how cities are imagined: thinking of disability as a medical trait emphasizes individual responsibility, and thinking of disability as socially constructed and experienced emphasizes issues of inclusion and accessibility.
- Inclusive design allows ableism to be challenged, as it invites consideration of a wide diversity of human experiences and needs, rather than of particular norms of functionality and associating stigma with individuals who diverge from these norms.
- Geographies of mental, emotional, and physical impairments are closely intertwined with the economic, political, and social processes and phenomena driving city changes (e.g., neoliberal processes of public-service cuts and of privatization of urban spaces has led to reduced access to certain spaces for individuals experiencing physical disabilities and/or mental ill health).
- The Georgetown case study reveals how poverty is intimately connected with disability, where a lack of resources limits disabled people's ability to access the city, as well as their ability to advocate for disability rights.
- The Liverpool case study with visually impaired young people demonstrates that disability is very much a social experience and that the way people are treated by others in public space can be more of a barrier than any physical impairment.

- In Canadian cities, the lives of individuals experiencing mental distress are intertwined with histories of deinstitutionalization, neighbourhood changes, and concentrations of mental health resources, with severe forms of exclusion linked to mental health but also to stigma and poverty (e.g., heavy policing, NIMBYism, and gentrification).

<1>Activities and Questions for Review

1. Draw your own version of the medical, social, and embodied social models of disability. What are the differences between these models?
2. In a small group, discuss how ableism is reflected in your journey from home to the university campus and to this classroom.
3. In pairs, discuss how levels of mental and emotional stress can be affected by exposure to the urban built environment and the social relations that animate it.
4. Based on the case studies in this chapter, compare and contrast how disability is differently experienced in cities of the global North and global South.

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Figure 19.4 Map of Liverpool (Source: OpenStreetMap)

Figure 19.5 Independent mobility: a visually impaired young person travels through the city (Source: CNIB/Paul Darrow, 2014)

Figure 19.6 Saint-Roch Mall, 1974 (Source: Archives de la Ville de Québec, N030805)

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