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State Classifications of Mental Illness in France and the United States

By

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Committee in Charge:

Professor Marion Fourcade, Chair
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Professor Thomas Laqueur

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Abstract

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This dissertation examines how public mental health care systems in France and the United States treat similar diseases while producing very different kinds of mentally ill subjects. Through ethnographic observations of clinics, welfare offices, and courts, three hundred interviews with professionals and policymakers, and government archives, I document the seemingly chaotic and disordered trajectory of severely mentally-ill persons in the post-asylum era. The fragmentation and conflict in each country is consistent with literatures in medical sociology on mental health systems organization and with the sociology of professions.

I argue, however, that there is nonetheless an underlying order to these trajectories in each country. Medical actors and bureaucrats—such as judges, psychiatrists, and social workers—use shared, culturally-specific categories to divide between normality and pathology, disability and functionality, and dangerousness and deviance. In France, a common vision treats the mentally ill as a distinct class of persons with a deep-seated, troubled subjectivity that molds their entire life. This reproduces a system based on specialized, segregated services. In the United States, a perception of mental illness as primarily a behavioral problem—in the same vein as drug use or general delinquency—underpins a shared jurisdiction between different institutions of poverty governance. In place of typologies, the United States locates individuals on a simultaneously moral and medical continuum between failure and redemption, fluctuating based on personal discipline and medication compliance. The result is profoundly different distributions of the severely mentally ill between institutions of care and control.

These results suggest that the literatures on medical classification, professions, and bureaucratic decision-making need to better account for broader differences in state structure, national culture, and conceptions of the self which set the terrain of professional and bureaucratic conflict and underpin medical diagnoses.

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Preface

"Did you know that psychiatric practices are very different between countries? And that the government is very involved in psychiatry?" My ears perked up. It had been a long day of fieldwork, but all of a sudden, I thought, "This person is describing my dissertation." They were doing it, improbably, from the witness stand of a hearing held in a hospital in New York City. His psychiatrist had just testified he had paranoid schizophrenia, and this person's current reflections on psychiatry were, at least to the judge, confirmatory enough to keep him in the hospital. But as far as I was concerned, he was on to something.

Writing and researching this dissertation has made me more and more skeptical of the idea that we all exist on the same continuum of psychic well-being and that most of us will dip into illness at some point in our lives. The people suffering from conditions like schizophrenia about whom this dissertation is written face a qualitatively distinct set of challenges that I fear have been washed out by claims of ubiquitous mental health issues. I found out a few months after that hearing, though, that the difference between researcher and psychiatric patient can be just a few months' time. When I told the ER clinicians tending to me it might be interesting to turn the experience into an "auto-ethnography," I could see they saw me as just as crazy as the person I observed in New York.

I'm not sure if the challenges I faced while researching and writing this dissertation would quite move me from what the French call someone with mere "*troubles psychiques*" to the realm of a real "*malade mental*." But it's safe to say that this dissertation does not come from a place of complete personal detachment from its subject matter. The final product bears the imprint of some of the challenges, not all of them intellectual, I have faced in the last eight years, and it exists only thanks to the people who stuck with me through them.

Marion Fourcade certainly had to learn more about mental illness and in a more direct way than she bargained for. She stuck with me through it all while always steering me back to the sociological questions at hand. Her work was an inspiration before I started my dissertation; now, her mentorship, too, is a model for me to follow. I could not have asked for a better advisor.

I am appreciative of the help from the other members of my committee, Neil Fligstein, Armando Lara-Millán, and Thomas Laqueur. Michael Burawoy somehow escaped this committee but did not escape me. Thank you to Dan Lewis for being a great additional guide these last years and Patricia Fernandez-Kelly for always watching over me. Laura Enriquez and Sam Lucas were also particularly supportive in the process. Carolyn Clark, Anne Meyer, Catherine Norton, and Tamar Young variously let me cry in their offices, helped me when I got locked out of mine, and generally made the department a livable place to be for the extended adolescence of graduate school.

I am grateful to the institutions that funded my research, including the Berkeley Empirical Legal Studies Fellowship, Institute for International Studies, the Institute for European Studies, the Georges Lurcy Foundation, and the Chateaubriand Fellowship. Gisèle Sapiro and the European Center of Sociology at EHESS provided a wonderful institutional base for my field research; the MaxPo Center at SciencesPo and Olivier Godechot provided a much-appreciated academic shelter at key moments. Qualitative researchers live off the good will of their research subjects, and I was lucky to find literally hundreds of people willing to share their time and knowledge with me. I hope this dissertation does justice to their difficult work.

I promised myself I wouldn't try to list off every person who helped me along the way, but there are a few academic (although not limited to academic) interlocutors I simply can't leave out: Lindsay Berkowitz, Dani Carrillo, Martin Eiermann, Jason Ferguson, Chris Herring, Véronique Irwin, Andrew Jaeger, Matty Lichtenstein, Noémie MP, Santiago Molina, Isabel Perera, Jane Pryma, Manuel Rosaldo, Jason Scott, Caleb Scoville, Josh Seim, Mary Shi, and Rebecca Tarlau. One of my favorite parts of the dissertation process was working with my amazing research assistants, Jessica Cohn, Sébastien Le Moing, Michael Long, Kimberly Nielsen, Amritha Somasekar, Sierra Timmons, and Didi Wu. If I have any good ideas, they would not as much so without having discussed them with Tonya Tartour.

For more human support, I am grateful to Nick Antipa, Kristina Cohen, Elizabeth Cruikshank, Sylvia Herbert, Sam Leachman, Kiley Stout, Tolan Thornton, Mia Tsui, Eti Valdez-Kadinsky, and Alia Whitney-Johnson. Thank you to Jordan Bubin for literally everything. Additional organizational thanks go to UAW 2865, the PUB, WCBC, the Citadel, ~~the Euros~~ *les pièces rapportées,* the Woolsey Mammoths, and the Menzingers. My parents helped me bear many of the emotional burdens of this process and never let it seem like a burden themselves (the Mourad family carried its fair share of the weight, as well). Marie Mourad knows better than anyone what my (downward) academic trajectory would have looked like without her.

I dedicate this dissertation to Sara and John.

Author's Note

This dissertation was at various times a comparison between the U.S. and France, then between Paris and New York, before becoming just about France, until California was added to the mix. What was initially to be written as a book draft became a series of three (then four) articles, two of them comparative, two of them not. For the dissertation, I have replaced the word "paper" with "chapter" and tried to make the overall document flow. However, some things (like methodology sections) are repeated, and individual chapters contain their own literature reviews. Taking this into account should help the reader navigate.

Introduction: Precarious Patient-hood

"Les malades mentaux sont des hommes comme les autres, mais ce ne sont pas des malades…comme les autres"
– Claude Veil (1956)[1]

Hippocrates saw, from the start, that the struggle over how to treat the mad started with a debate over who the mad actually were. Insanity seemed like proof to the Ancient Greeks that they were puppets in the hands of capricious gods. They missed, the Hippocratics countered, that madness was "nowise more divine nor more sacred than other diseases, but has a natural cause from which it originates, like other affections" (qtd. in Scull 2015:32). Hippocrates lost the argument. Up through the middle ages, as Foucault (1964:43) observes, "the madman was not a sick man" at all. Even some physicians believed they were "as mad as wild beasts" and did "[not] differ much from them."[2] Like animals, they were left to roam freely in the best of cases and chained and brutalized in the worst.

By the 18th century, the severely mentally disordered had recovered a measure of their humanity, but only to be lumped indiscriminately with aged, infirm, and dependent poor in the English poorhouse or the French *Hôtels Dieux*.[3] In 1797, the Parisian mad-doctor Phillipe Pinel faced this mass of abandoned and abused humanity and lamented their condition, "so destitute…we found it impossible to class our patients according to the varieties and degree of their respective maladies" (Pinel 2010:100). He freed the mad from their chains and, equally importantly, from their intermingling, taking the "melancholics" and "maniacs" back with him to his clinic and leaving the "demented" and "idiots" behind (Gauchet and Swain 1980:206).

The asylums he and other enterprising proto-psychiatrists spread through the Western world served as symbols of scientific progress and humanism. These were to be specialized medical institutions: as a legislator advocating for a national system of asylums in 1837 France put it, "the establishments for madmen should consecrate themselves exclusively to this type of malady" (qtd. in Beaudouin and Beaudouin 1967:39). "Moral treatment," as it was practiced inside, presumed that the mad "needed to be treated essentially like children" and "required a stiff dose of rigorous mental discipline" (Porter 1989:19). But the madman "remained in essence a man" (Scull 1989:88), a fragment of reason intact. Early asylums were a "battlefield over the truth of illness" (Foucault 2008:7) in which psychiatrists attempted to impose a medical definition onto conditions whose sufferers perceived them otherwise. The psychiatrists largely seemed to win.

We know how this erstwhile triumph ended. The ontological status of the mad-person as a human being was no longer in doubt, but their treatment did not always reflect it. Erving Goffman (1959:126) wrote of one of these temples of progress, Saint Elizabeth's hospital in Washington D.C., that the mental patient "starts out with relations and rights, and ends up…with hardly any of either." A 1966 report by a commission in the State of California observed that public hospitals had become "a bin marked 'miscellaneous' to receive every personnel problem facing society."[4] A failure to properly classify was, in critiques of the asylum, intensely imbricated with a failure to properly treat.[5]

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[1] Translation: "The mentally ill are men like any other, but they are not sick people like the others."

[2] William Salmon (1686), quoted in Scull (2005:49).

[3] The intermingling of the mad with other marginalized populations in the poorhouses of the Anglo-Saxon world and *Hôtels Dieux* in France is documented by Katz (1996) and Castel (1988), respectively.

[4] Subcommittee on Mental Health. 1966. *The Dilemma of Mental Commitments in California*. Sacramento, CA: California State Legislature: 13. Thank you to Yoshi Cohn for finding this excellent quotation.

[5] The degree to which the critique of jails and asylums has hinged on claims that they do not properly separate their inmates is developed by Simon (2016).

The shuttering of asylums over fifty years of de-institutionalization has returned to the Pinelian project of sorting the mad, albeit through dispersing them across many kinds of institutions rather than concentrating them in just one. The aged went to nursing homes and the disabled to supported living arrangements[6]; the mentally ill—emphasis on the *ill*—would receive medical care on an outpatient basis, integrated into the community. The reality that mad people are, in the end, just sick people seems confirmed by an expanding range of pharmaceuticals that alter symptoms by altering the physical properties of the brain. As President Clinton told a 1999 White House Conference on Mental Health, "We must make it clear, once and for all: mental illness is no different from physical illness" (qtd. in Albee and Joffe 2004:419). The argument has only become more convincing with the advent of MRIs and growing attention to bio-markers—from genes to gut bacteria—that show that "these are real diseases of a real organ" (qtd. in Albee and Joffe 2004:419). "Leaders in the mental health field—fiercely dedicated advocates, scientists, government officials, and consumers—have been insistent that mental health flow in the mainstream of health," the U.S. Surgeon General noted in 2001, adding, "I agree."[7]

Hippocrates would be proud. A careful observer might be skeptical. In 1958, the French state finally got around to changing "madman" to "*malade*" in the *Code de santé publique*, but the once-mad sick person still stands apart. After all, in France today, more than half of all psychiatric hospitalizations take place in "Specialized Hospital Centers,"[8] which actually contain only one medical specialty, psychiatry. Their patients might feel very far from the "mainstream of health" when their doctors exercise a power granted to essentially no other discipline—the power to impose treatment on people who are explicitly refusing it.[9] Even in the U.S., the narrative of declining mental health "exceptionalism" (Frank and Glied 2006:xii) is belied by brute bureaucratic fact. The pile-up of psychiatric diagnoses and medications that sociologists often cite as evidence of "medicalization" are more frequently imposed on "inmates" than on "patients."[10] The severely mentally ill are more likely placed in group homes than in hospitals (see Davis et al. 2012)—intermingling with precisely the other marginalized or drug-addicted people from which Pinel sought to separate them.[11] In short, the status of the severely mentally disordered as "sick" and of responses to them as primarily "medical" has always been, and continues to be, remarkably tenuous.

This dissertation examines this "permanent indecision as to the nature of madness and its social status" (Jaeger 1981:41) in modern France and the United States. I explain the process by which people with illnesses like schizophrenia are distributed across institutions of care and control at divergent rates and through disparate processes of decision-making. I build on existing studies on mental illness in medical sociology in two central ways. First, much research has embraced the claim that, as French sociologist Robert Castel (1988:150) put it, "the diagnosis determines the institutional fate." To that end, scholars have produced a host of books critiquing the proliferation

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[6] This process is described by Bagnall and Eyal (2016).

[7] Surgeon General. 2001. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services.

[8] See Ministère de la santé publique. *Décret n°72-1078 du 6 décembre 1972 relatif au classement des établissements publics et privés assurant le service public hospitalier.* Paris, France.

[9] The rise in involuntary care in France is shown by Coldefy, Magali, Sarah Fernandes, and David Lapalus. 2017. *De l'hospitalisation aux soins sans consentement en psychiatrie : premiers résultats de la mise en place de la loi du 5 Juillet 2011*. N° 222. Paris, France: Institut de recherche et documentation en économie de la santé.

[10] The most reliable figures on the prevalence of severe mental illness among inmates are provided by Raphael and Stoll (2013), Yoon et al. (2013), and Lamb and Weinberger (2005).

[11] The importance of a designation of "disability" in the social trajectories of the mentally ill in the U.S. is documented by Hansen et al. (2014) and Estroff (1981).

of disease entities in the Diagnostic and Statistics Manual—the "bible" of psychiatry—and their use to medicalizing steadily-growing swathes of human psychological experience.[12]

However, to understand what is happening to the severely disordered, I argue, we need to look beyond the *diagnosis of illness* towards the *classification of people*. Today's diagnostic criteria for schizophrenia are not so different from those given by Emil Krapelin for "*dementia praecox*" at the end of the 19th century (Insel 2010; Kendler and Engstrom 2016). The medications for that illness have improved only marginally from the anti-psychotics discovered at Sainte Anne's hospital in Paris in the 1950s (Lieberman et al. 2005). What has changed radically is *where* those diagnoses and treatments are delivered and *to what kind of bureaucratically-recognized people*. Understanding the contemporary trajectories of the severely disordered, I show, requires examining ongoing struggles over more fundamental questions than medical labeling: are the mentally disordered diseased, and if so, are they diseased in the same way as those suffering from non-mental illnesses? Are they deserving and disabled, or socially and economically dysfunctional? Are their behaviors merely disruptive, or actually dangerous? Psychiatrists play an outsize role in answering these questions in both the U.S. and France, but not a unilateral one.

Second, many observers would agree with the assessment of President Bush's "New Freedom Commission on Mental Health" (the last serious federal government discussion of overhauling mental health care in the U.S.) that the system is "fragmented and in disarray."[13] In France, the narrative as put by two psychiatrists' widely-publicized book, *Psychiatry: The State of Crisis,* is that the system "is cracking up everywhere" (Leboyer and Llorca 2018:20). Little surprise that ethnographies of the management of the mad at ground level typically portray haggard professionals torn between impossible demands to deliver care and reduce costs, to preserve patients' rights while controlling their disordered behavior.[14] The field of mental health is riven with struggles over responsibility and jurisdiction between psychiatrists, social workers, administrators, and lawyers.[15]

I find similar patterns of professional conflict and confusion in each country. When we look comparatively, however, we nonetheless see consistent and stable differences in how the severely mentally disordered are classified and governed. My explanation centers on the role of the state, less as a purveyor of coherent policy—here, I see mostly contradiction and indifference—and more in its capacity, as Bourdieu (1994:7–8) phrases it, to "mold mental structures and impose common principles of vision and division" on state agents. Across six ethnographic field sites that include clinics, welfare offices, and courts, I find that the French consistently treat the mentally ill as people with a troubled subjectivity that sets them apart not just from the healthy but also other sick people, people living with disabilities, and people involved in the criminal justice system.[16] In the U.S., these categorical boundaries are replaced with continua, and interventions share a common goal of controlling behavior and improving functioning that makes fewer separations between problems caused by poverty or pathology. This dissertation is thus a case study in the "close linkages between

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[12] Any list of citations is likely to be partial. In addition to vitriolic popular critiques of the DSM (Greenberg 2010; Kutchins and Kirk 1997; Whitaker 2011), sociologists have produced their own, more careful, studies of transformations in psychiatric nosologies (Horwitz 2001; Schnittker 2017; Strand 2011). This diagnosis-centered framework has been a jumping-off point for studies on the manufacture of new illnesses or expansion of old ones, like ADHD, PTSD, or Female Sexual Dysfunction Disorder (Conrad 2007; Hinshaw and Scheffler 2014; Jutel 2011; Young 1997).

[13] President's New Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: 3.

[14] Exemplary ethnographies in the U.S. include Estroff (1981), Scheid (2004), Brodwin (2012), and Dobransky (2014). For France, I draw particular inspiration from Velpry (2008) and Eyraud (2013).

[15] See Abbott (1988), Strand (2011), or Horwitz (2001).

[16] This is not saying that these groups are actually separated in practice. As in the U.S., for example, many French professionals document the seemingly growing prevalence of mental illness in prison (see Falissard et al. 2006).

the ways in which human beings are understood by authorities and the ways in which they are governed" (Rose and Abi-Rached 2013:7), and in turn the intimate connection between medicine and the state and the role of country-specific culture in constituting both.

Terms and Translations

There are, they say, no atheists in the trenches, and there are no pure social constructivists in the Psychiatrist Infirmary of the Parisian Prefecture of Police (IPPP). It is here that people who have committed crimes or "gravely troubled the public order" are brought for a psychiatric evaluation, which will send them either to the hospital or to jail. It's almost a caricature of psychiatry as a discipline of social control. But the very first clinical presentation I saw there, a man stared at the camera and declared, "I'm god, I'm a shooting star, I'm going to kill you." The IPPP processes its fair share of malingerers, but he certainly wasn't one of them.

This dissertation assumes that madness—"massive and lasting disturbances of reason, intellect, and emotion" (Scull 2015:11)—is ontologically real. Social factors may shape its prevalence and culture may shape how it is expressed, but all societies have a small proportion of individuals who, for unknown reasons,[17] have a "lack of intersubjective reality" (Estroff 1981:222) with those around them. These conditions "perturb in a durable and important fashion the whole of interactions and social memberships of the person" (Velpry 2008:27).

I speak of these persons, around whom this dissertation revolves, as suffering from "severe mental disorders." The term "disorder" evokes, deliberately, normative evaluations. To call something "disordered" is "code for a vision of the world that ought to be orderly…Truth, the true person, is disrupted by disorder" (Hacking 1998:17). There may be societies where these individuals would be left to their own devices or celebrated as visionaries, but in France, the U.S., and most developed countries, severe mental disorders are sufficiently disruptive to beg for intervention.

That intervention frequently if not always involves defining these disorders in medical terms. It is in the process of identifying behaviors and mental processes as "symptoms" and grouping them together into "diagnoses" that they become "severe mental illnesses." Across my field sites, "severe mental illness" are, at least 80% of the time, schizophrenia[18], bipolar disorder, and severe depression. Personality or substance use disorders, both of which appear with some regularity in my ethnographic observations, are more contested in their status as truly "mental" and as genuine "illnesses."

The current best practice is to refer to "people with mental illness" or "people with schizophrenia" rather than "the mentally ill" or "schizophrenics," and I try to follow that convention in general discussions thoughout. "Mad" belongs alongside terms like "queer" as a pejorative label that has been, at least partly, reclaimed. Virtually no one I spoke to used it, but I occasionally do to emphasize the historical and geographic universality of the disorders I discuss.

When I talk about my field sites and data directly, though, I largely follow the terminology used by my informants. For me, the language professionals use is not simply different terms attached to the same thing, but part of the way these professionals constitute who the mentally disordered actually are differently. For example, in France, most medical professionals speak of "patients"; in the U.S., the preferred label is "clients" (or, to a lesser extent, "consumers").

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[17] In general, when medical science finds an organic cause for a disorder, as was the case for "general paresis" (eventually attributed to syphilis) or Alzheimer's, it ceases to be the domain of psychiatry (Horwitz and Grob 2016).

[18] Although in France this might be called simply "psychosis," in the U.S. it could also include schizo-affective disorder, schizophrenia spectrum disorder, or psychosis not-otherwise-specified.

The most important French translation issue is posed by "*malade*" (or "*malade mental*"). Although "sick person" is a correct translation, it is not neutral that in the French language you can be a "sick" without the word "person" necessarily appended. As such, I often use *malade* or *malade mental* untranslated. Another complex term is "*soins*." Its meaning is broader than "treatment" and closer to "care," which is usually how I translate it. That said, my sense is that in French "*soins*" has a more specifically medical connotation than "care," even if acts of "care" extend beyond what is generally recognized as medical treatment.[19]

Part of this dissertation deals with the question of the relationship between mental illness and "*handicap psychique*." "*Handicap*" can be translated either as "handicap" or "disability" (the latter now being the preferred term in the U.S.). To help keep track, I speak of "psychic handicap" when discussing the particular label attached to people with severe mental illness and "disability" when writing about the broader population of people with sensorial, intellectual, cognitive, or physical handicaps. The system that serves this latter group in France is called the "medical-social" sector, which emphasizes its institutional positioning between the properly "medical" system directed at the sick and the "social" system aimed at the poor. For simplicity, I refer to it as the disability system.

Background: The Mental Health Field in France and the U.S.

A comparative sociology of mental health systems must start from their double specificity. First, although sociologists have produced a rich literature analyzing how social policy coheres into distinctive "regimes" in different countries, health systems often deviate from these ideal types (Bambra 2007; Beckfield, Olafsdottir, and Sosnaud 2013; Carpenter 2012). In both France and the U.S., the health system is more universalistic and generous than other wings of the welfare state (Palier 2005; Quadagno 2010).[20] Even within health systems, mental health care has long followed distinctive principles. Paradoxically, psychiatry has been the object of early and intensive state interest while simultaneously being relegated to a "poor relation to other social commitments…without integration into the modern welfare state" (Mechanic and Rochefort 1990:324; see, also, Carpenter 2000). Moreover, even if there are some consistencies in mental health systems within health system and welfare regime clusters—Anglo-Saxon countries closed their hospitals much more rapidly than continental European ones, for example (Goodwin 1997)—the exceptions are glaring. Conservative Italy was marked by one of the most radical projects of transforming the social status of the mentally ill in the 1970s (Burti and Benson 1996; Donnelly 1992). The gentle Scandinavian welfare states have been slow to close institutions and enthusiastic about new forms of coercion (Zetterberg, Sjöström, and Markström 2014).

My point is that an analysis of mental health systems must chart their peculiar development historically. An obvious and frequent starting place is the fulcrum of de-institutionalization. By the 1950s, France and the U.S. were home to some of the largest psychiatric institutions in the world (Goodwin 1997). In both countries, a movement of reform within psychiatry, the introduction of neuroleptics, and the creation of health insurance and disability programs to finance care outside of hospitals drove a dramatic closure of beds.[21] This "earthquake" demolished an asylum system that

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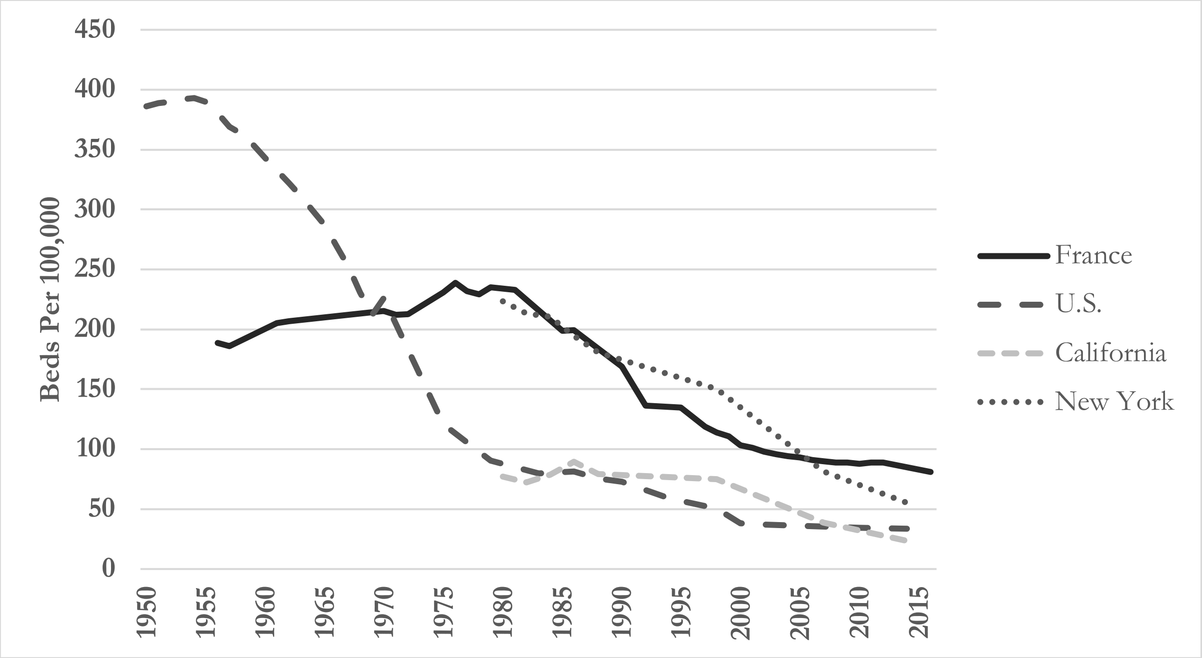
[19] One report contains has a long discussion of how "care" does not translate well into French. Hardy-Baylé, Marie-Christine. 2015. *Données de preuves en vue d'améliorer le parcours de soins et de vie des personnes présentant un handicap psychique sous tendu par un trouble schizophrénique.* Centre de preuves en psychiatrie et en santé mentale.

[20] Its particularly universalistic health system is part of why France has been difficult to firmly place in the "Conservative / Corporatist" or "Southern European" worlds of welfare capitalism (Arts and Gelissen 2002; Wendt 2009).

[21] The role of new financing mechanisms and psychiatric reformers in driving de-institutionalization is relatively consensual in the U.S. (Grob 1991; Scull 1977) and France (Henckes 2011b). The role of medication is more ambiguous because it initially served to render the asylum more manageable and therapeutic (see Gronfein 1985; Starks and Braslow

Figure 0.1: Decline in Psychiatric Hospital Beds in France and the United States (1955-Present)



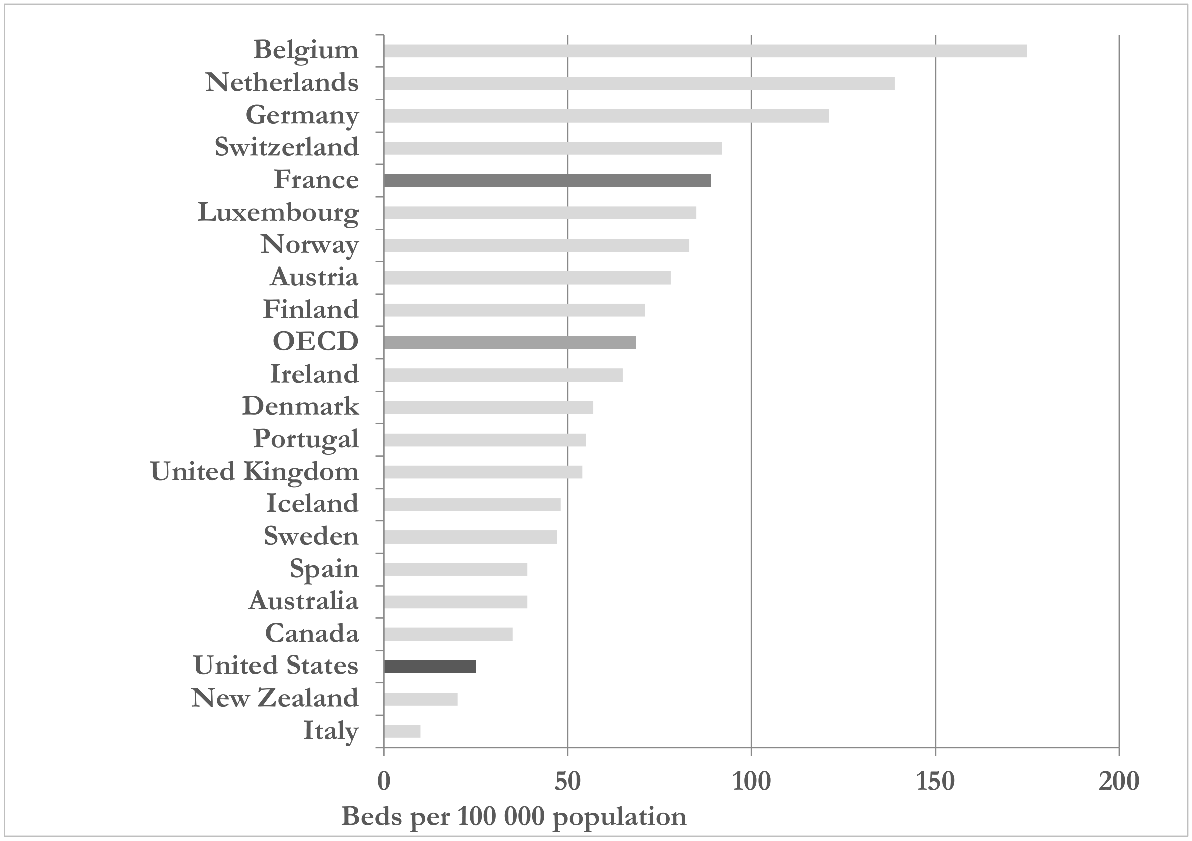
Source: French National Statistical Yearbooks; Mental Health United States (1980-2012)

had been relatively stable for over 100 years. De-institutionalization served as a "moral blender" that "scrambled…[the] categories" that defined the mentally ill in hospitals and lay the groundwork for treatment in the community (Eyal 2010:3). But despite apparently similar starting points, their pathways diverged (Figure 0.1): the U.S. started rapidly in the 1960s and shuttered 90% of beds in state hospitals, while France continued construction of psychiatric hospitals into the '70s and today is among the top five Western countries for bed density (Figure 0.2).

In this section, I take a longer view, arguing that these divergent trajectories of de-institutionalization emerged from the intersection of new problems with longer-running patterns in how state institutions responded to the mentally ill. I am thus influenced by Dobbin's (1994:3, 23) conception of national repertoires of policymaking. As he argues, administrators and elites respond to novel situations by drawing on preexisting understandings of the "locus of public authority," "the nature of the legal system," "the system of…public office holding" and "public fiscal capacity." The key actors in conflicts over the future of the mentally disordered thus "enter into struggles and transactions…with points of view, interests, and principles of vision determined by the position they occupy in the very world they intend to transform or preserve" (Bourdieu 1996:2). These cultural and cognitive conceptions shaped how each country responded to the key institutional questions posed by de-institutionalization: the role of psychiatry, the place of the hospital in community care, and the relationship between mental health care and the rest of the health, welfare, and judicial system. The institutional arrangements I lay out in this part of the introduction are the backdrop for the dissertation's four chapters, which deal with contemporary policy debates and the process of classification as it plays out in practice.

2005). I leave the role of anti-psychiatry and civil rights movements, which were certainly stronger in the U.S. but whose impact was nonetheless limited (see Appelbaum 1994), for the Appendix.

Figure 0.2: Psychiatric Bed Density, Western-OECD (2011)



Source: OECD Health Stat.

France: Unified System, Protected Subjects

The Age of the Asylum and the Long Shadow of 1838

History weighed heavily on my French informants. In a 2014 power-point on the technicalities of mental health financing, a psychiatrist working in the High Authority of Health observed:

> It is never useless to remind ourselves that French psychiatry was born at the Salpêtrière [a hospital] with Philippe Pinel, a doctor who wanted to understand and care for mental illness in the movement of ideas of the French Revolution, while the birth of Anglo-Saxon psychiatry was associated with William Tuke, a rich tea and coffee salesman…who created a religious, non-medical establishment…considering the *malade* like a deviant child.[22]

For French psychiatrists, there was an intense imbrication between the social statute of the mad and the stature of the profession that arose to treat them. Observed the head of the main psychiatric union in 1995, "The *malade mental* is an inconvenient being who is expensive…His natural defender is psychiatry, image and mirror of madness. Their destiny is linked" (Ayme 1995:9).

The mad in France were made the objects of a specialized set of institutions and policies decades before comparable state responses to poverty, old age, or illness more broadly. Amidst the

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[22] Halimi, Yvan and Christophe Schmitt. September 19, 2014. "L'harmonisation des pratiques en psychiatrie: un préalable à une tarification." Presented at the Journées Nationales de l'information médicale et du Contrôle de Gestion en Psychiatrie. Poitiers, France.

chaos of the post-revolutionary period, the Minister of Interior declared in 1837 that insanity "demands most imperiously the solicitude and the intervention of the Government" (qtd. in Goldstein 1987:281). The (in)famous 1838 "Law of Madmen" mandated that every department in France construct an asylum dedicated specifically to the mentally ill, in which the prefecture could deposit those who "gravely troubled the public order" and doctors intern those for whom the "necessity of treatment was manifest."[23] The law linked administrative and medical power, to the exclusion of the judiciary. This made it an easy target for critiques of the imbrication of psychiatry with projects of social control (Castel 1988; Foucault 2008; Goldstein 1987). But this is not how many French psychiatrists see it. As a 1992 report laid out:

> The madman, of the beginning of the 19th century, was not considered as a sick person having a legitimate right to a specific response. Left out, no structure welcomed him. The law of June 30th, 1838 induced a remarkable advance that acknowledged the mentally ill person's right to assistance, by instituting the asylum. This text created an exclusive system which…could manage this population, and which had its own organization and rules.[24]

The law founded psychiatry as a "great public discipline in the service of the collectivity" (Interview, 7/7/16), what Goldstein (1987:276) calls a "statist" profession not just certified by but integrated into the functioning of the French state (see, also, Abbott 1988:26).

The question of whether psychiatry existed to provide care or to ensure social control was one of the lingering anxieties about the law, which was only partly abrogated by reforms in 1990 and 2011. But the sluggishness with which the departments built the asylums the law mandated spoke to another concern: that, despite its official solicitousness for the mentally ill, the state never cared much for these "inconvenient" and "expensive" beings.[25] Worse, while Pinel (2010:99) believed that it was in "great hospitals and asylums" that the "energies of medical philosophy" would flourish, psychiatrists were quickly consigned to a "dominated position within the medical field" (Pinell 2012:137). Often the sole doctor presiding over establishments with hundreds of mentally ill, psychiatrists served as "builders, organizers, managers, and politicians…a doctor whose exercise is in truth…very far from medicine" (Gauchet and Swain 1980:282). Arguably one of the earliest specialties of medicine, it was as of the 1960s not recognized as such by the Ministry of Education (Pinell 2004:3). Instead, "doctors of [public] psychiatric hospitals" had the statute of functionaries, named by the state to roles that were almost purely administrative.

The 'Massacre of the Mad' and the Birth of the Secteur

The law of 1838 remained the only piece of public policy specifically directed at the mentally ill well into the 20th century. Over time, enterprising psychiatrists and policymakers sought to reframe the social problem of mental illness from that posed by dangerous individuals to that of a collective epidemic. In the 1920s, Edouard Toulouse opened the country's first "free" psychiatric ward, into which patients could enter voluntarily rather than be placed under the mechanisms of the

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[23] *Loi n° 7443 sur les aliénés du 30 juin 1838.* Retrieved July 14, 2019 (https://www.ascodocpsy.org/trouver-de-linformation/textes-officiels-historiques/).

[24] Massé, Gérard. 1992. *La psychiatrie ouverte: une dynamique nouvelle en santé mentale: rapport.* Paris, France: Ministère de la santé et de l'action humanitaire: 43. 150 years after its passage, in a survey reported in a 1988 report, 70% of psychiatrists wanted the law of 1838 to be maintained in some form. Zambrowski, François. 1986. *Moderniser et diversifier les modes de prise en charge de la psychiatrie française.* Paris, France: Ministre de la Solidarité, de la Santé, et de la Protection Sociale: 34. For other positive readings, see Durand (2011) and Gourevitch et al. (2013) and Martin (2000) provide dissident perspectives.

[25] Nine departments never established a specialized psychiatric hospital (Coldefy and Curtis 2010), and in 1874 the state rendered departmental funding for the asylums "non-obligatory" (Rhenter 2013:14).

1838 law (Thomas 2004). Rather than taking as his inspiration "general" medical hospitals, though, Toulouse modeled his program off of "prevention centers" for tuberculosis (Murard and Fourquet 1975:59). In parallel, government responsibility for asylums passed from the Ministry of the Interior—in charge of policing and security—to the Ministry of Hygiene, Assistance, and Social Planning (Jaeger 2012:17–18). The left-wing governments of the "Popular Front" in the 1930s pushed this extension of collective responsibility for the mentally ill further. After noting that "fight for preventative mental medicine has fallen behind that of other social plagues," it called on the departments to create "dispensaries of mental hygiene."[26] These structures would help to prevent the mentally ill person from becoming a "danger to himself or his entourage" and thus avoid "heavy and unproductive costs for the collectivity."

The real transformation of the French psychiatric system, however, emerged from the "Massacre of the Mad" in World War II, a moment that clearly still evoked shame among psychiatrists 70 years later. During the occupation, a third of asylum residents—43,000 people—died of disease and famine, a tragedy underpinned by the indifference of a society that had provided for only 207 public psychiatrists nationwide.[27] One old psychiatrist told me:

> After the war, there was a big movement in psychiatry born of the consciousness of all those *malades* who died of hunger in the hospitals and the image of… [hesitates] well, the assimilation that you could make, the linkage, between the hospital as it was, the asylum, and the concentration camps (Interview, 4/5/16).

Death rates were lower in hospitals where head psychiatrists had built farms in the name of "therapeutic work" for patients or which had developed connections with surrounding communities that could provision the hospitals and provide "family placements" for stabilized *malades*. These experiences became the basis for "institutional psychotherapy": a movement that, by integrating the *malades* into the life of the institution, sought to "heal the hospital to heal the sick"[28] (see Brossard 2013). One can see already, in 1945, features that still define French mental health care: a reformed—rather than abandoned—psychiatric hospital, headed by psychiatrists with a special obligation to protect their vulnerable charges.

Outside of the hospital, other psychiatrists were experimenting with community based treatment, which culminated in the release of a ministry *Circular* on the "fight against mental illness" in 1960 (Henckes 2009, 2010, 2011b; Murard and Fourquet 1975). The circular declared a new policy of *sectorisation*, which:

> Consists essentially of dividing each department into a certain number of geographic *secteurs*, in the interior of which the same medical-social team will assure for all the *malades,* men and women, the indispensable continuity between screening, treatment without hospitalization when it is possible, care with hospitalization, and, finally, surveillance and rehabilitation.[29]

Given that the circular declared that "the majority of mentally ill pose problems…that are not fixed by hospitalization, and which hospitalization even makes more acute,"[30] it's easy to see how this

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[26] Ministère de la santé publique. October 13, 1937. *Circulaire relative à la réorganisation de l'Assistance psychiatrique dans le cadre départemental.* Paris, France.

[27] Azéma, Jean-Pierre. 2015. *Mission sur le drame que les personnes handicapées mentales ou malades psychiques ont connu dans les hôpitaux psychiatriques et les hospices français entre 1941 et 1945.* Paris, France: Ministère de la Défense: 8.

[28] Favereau, Eric. June 27, 1998. "Jean Oury, fou des fous". *Libération.* Retrieved July 5, 2017 (http://www.liberation.fr/societe/1998/06/27/jean-oury-74-ans-psychiatre-n-a-jamais-cesse-de-saint-alban-a-la-borde-de-vouloir-soigner-l-hopital-_239972).

[29] Ministère de la santé publique et de la population. *Circulaire du 15 Mars 1960 relative au programme d'organisation et d'équipement des départements en matière de lutte contre les maladies mentales.* Paris, France: 2.

[30] Ibid.: 12.

could be remembered as France's moment of de-institutionalization. Indeed, as in the U.S., *sectorisation* seemed to be born of left-wing critique, an "ideological cocktail" (Eyraud and Velpry 2012:3) that treated "caring for psychiatric patients" as "defending a politically alienated individual" (Henckes 2011b:169). Some partisans of the *secteur* even refused to wear white coats and had "beards and long hair" that shocked their staid, somatician colleagues (Ayme 1995:207–8).

But even if the communist party declared it a "remarkable victory" (qtd. in Jaeger 1981:158), a *sectorisation* policy that seemed radical at the time was modest in retrospect. It did not supersede the law of 1838 and thus the psychiatry's ineluctable role in delivering involuntary care (Eyraud and Velpry 2012; Henckes 2011b). Most importantly, though, it maintained a central role for the hospital—by design. The circular observed, "It is, in effect, indispensable that the *malade* leaving the hospital finds at the dispensary…the same doctor."[31] French commentators realized this distinguished their approach from that implemented elsewhere:

> In the United States, the system is very siloed, with community teams that have no relationship with the teams in the psychiatric hospital. The divorce is at a maximum. One should not confuse the community and the *secteur*. The *secteur,* it is the joining of the community and the psychiatric hospital (Murard and Fourquet 1975:219; see, also, Bernard et al. 1965:453).

In fact, the original circular declared that "the number of beds of which our country disposes for the hospitalization of *malades mentaux* if very insufficient."[32] It was released the same day as a parallel circular to transform hospitals to "suppress all the elements that give it… a carceral character."[33]

Only in 1974 did the state declare that "further increases in the number of beds will not be tolerated."[34] A 2015 report from the *Economist Intelligence Unit* ranked France 27th out of 30 countries for de-institutionalization, noting "unlike in many European countries, French psychiatric reform has never been aimed at reducing the central role of hospitals, per se."[35] In fact, when the *secteur* was fully inscribed into law in 1985, its budget was conferred to the hospital, which would then distribute it between the ambulatory structures of the *secteur* (like outpatient clinics, therapeutic apartments, or day hospitals) and inpatient units. *Secteur* psychiatrists had the statute of "hospital practitioners," even when they exercised outside it. In the 1990s, official policy followed international recommendations and embraced "the attachment of psychiatric sectors to general hospitals" as a "priority."[36] The goal was to reduce the stigma attached to psychiatry and to submit the discipline to the same techniques of economic rationalization applied to the rest of the health system (discussed in Chapter 1). But at present, three-quarters of French psychiatric beds are still in specialized hospitals (Figure 0.3), a powerful marker of the mental health system's enduring apartness.

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[31] Ibid.: 9.

[32] Ibid.: 9.

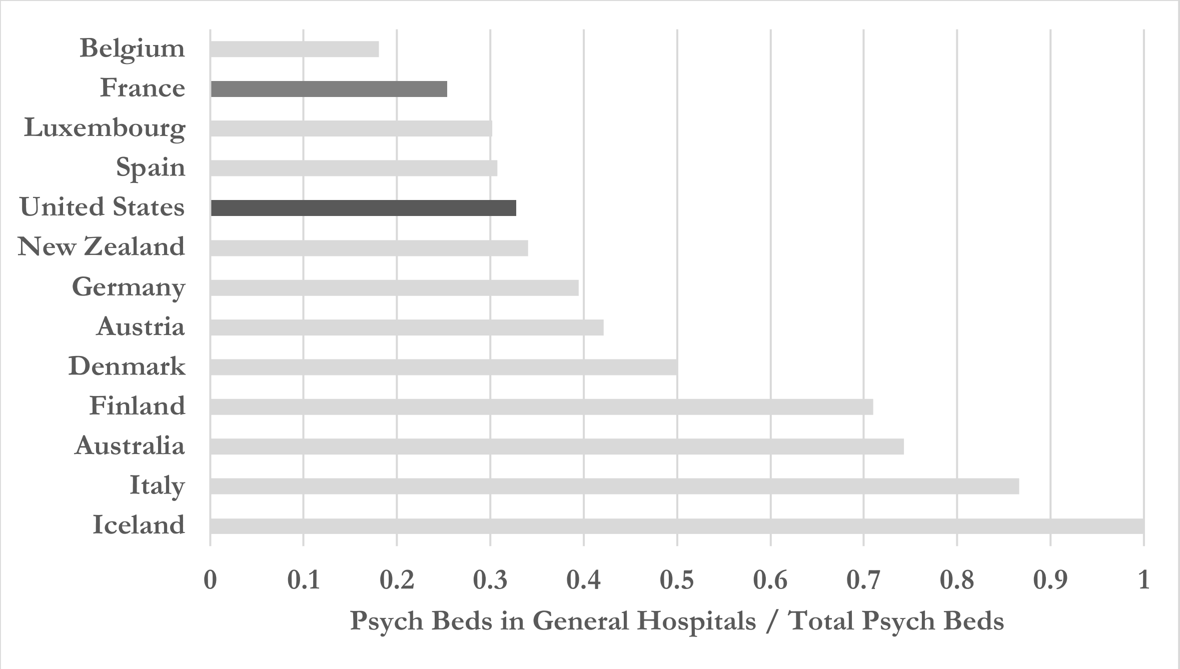
[33] Ministère de la santé publique et de la population. 1960. *Circulaire du 15 Mars 1960 relative au plan directeur des hôpitaux psychiatriques anciens*. Paris, France: 20.

[34] Ministère de la santé publique et de sécurité sociale. *Circulaire DGS/891/MS 1 du 9 mai 1974 relative a la mise en place de la sectorisation psychiatrique*. Paris, France: 5.

[35] Economist Intelligence Unit. 2015. *France Country Report: Political leadership is needed to build on early advances*. Retrieved April 17, 2019 (mentalhealthintegration.com): 3. This point is also made by Coldefy, Magali. 2012. *L'évolution des dispositifs de soins psychiatriques en Allemagne, Angleterre, France et Italie : similitudes et divergences*. n° 180. Paris, France: Institut de recherche et documentation en économie de la santé.

[36] Ministère de la solidarité, de la santé, et de la protection sociale. 1990. *Circulaire du 14 mars 1990 relative aux orientations de la politique de santé mentale*: Paris, France: 80.

Figure 0.3: Integration of Psychiatry Into General Hospitals (2014)



Source: WHO World Mental Health Atlas

The policy of *sectorisation,* in its own right, has been remarkably stable. Direct, public provisioning of treatment outside the hospital and care that is free at the point of service has no equivalent in the French health care system. In the 2000s, right-learning governments sought to "progressively efface the notion of the secteur" (Coldefy 2016:28) and confer its functions to private medicine. When the socialists retook control, though, the Minister of Health declared in a Parisian psychiatric hospital that "the model of the *secteur*…is more current than ever"[37] and reaffirmed it as the centerpiece of mental health care in a 2016 reform.[38]

That *secteur* model centers on integrated and accessible hospital and ambulatory care, delivered in proximity to the patient, with no requirement of payment or limits to its duration (Gittelman 2009; Petitjean 2009). The *secteur* is an example of the coupling of policies and institutions with cultural conceptions described by Dobbin (1994): the institution corresponds closely to how the problems posed by the mentally ill and their needs are themselves defined. As a member of the National Assembly commented:

> If we observe that we're talking about a chronic illness, for which hospitalization is not *the* solution but is from time to time *a* solution, but it needs to be articulated with other solutions…and add that the *malade mentale* should not be cut off from his family, personal, and professional connections… You can call it what you want, but you're going to wind up with the idea of the *secteur* (Interview, 6/22/16).

Indeed, when I asked my informants what 'worked' in the French mental health system nearly 2/3rds—including people in the health ministry or disability system who lamented the state of

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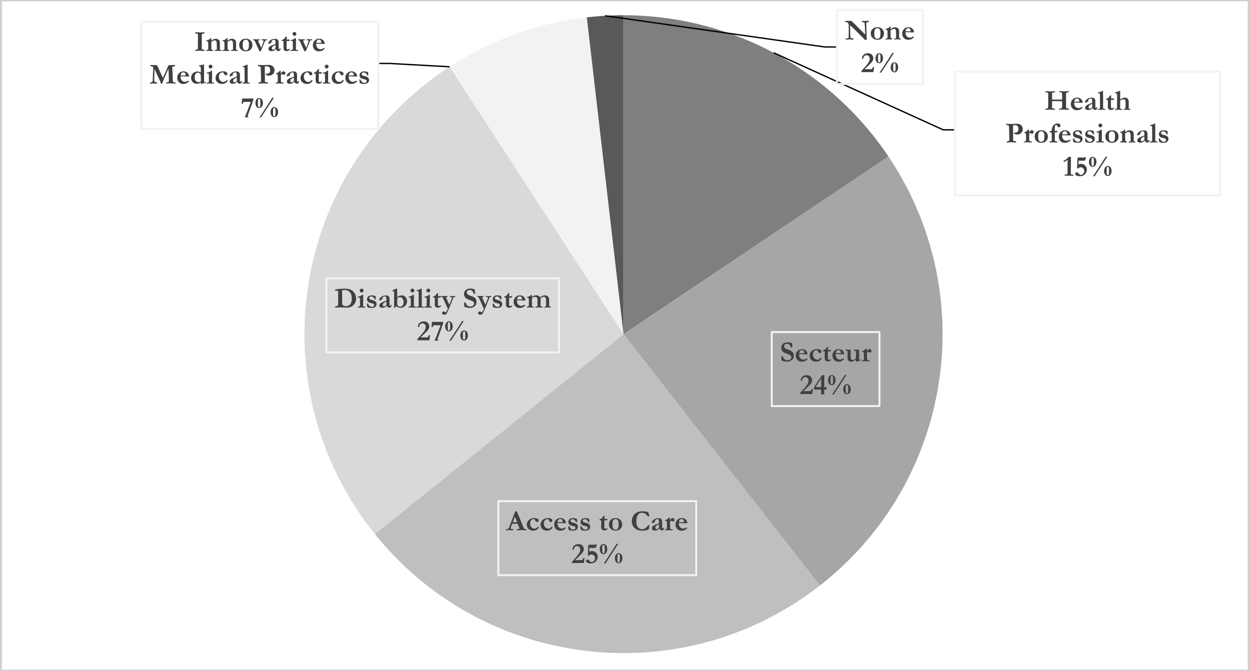
[37] Touraine, Marisol. September 24, 2014. "Politique de santé mentale et de psychiatrie, stratégie nationale de santé et projet de loi santé." *Ministre des Affaires sociales, de la Santé et des droits des femmes.* Paris, France.

[38] République Française. 2016. *Loi n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé.* Paris, France.

Figure 0.4: Positive Aspects of Mental Health System (France)



Source: Interviews with 110 French professionals and policymakers.

public psychiatry—nonetheless spoke immediately of the *secteur* itself, the professionals who worked within it, or the access to care it provided (Figure 0.4).[39]

French Psychiatry: A Discipline Unlike the Others

In France, public psychiatrists' dominance of the field of public mental health care is secure. Post-sectorisation, French hospital psychiatrists began agitating for a revision to their status that would provide them "parity" in treatment (and pay) with other specialists, but not "assimilation" (Ayme 1995:142) into a "rigid and restrictive conception that reduces psychiatry to a mere medicine of the technician" (Pinell 2004:11). This discourse that psychiatry was unequivocally a *medical* specialty harkened to the heritage of Pinell. But the notion that "psychiatry remains a medical discipline, but it cannot be one without a rigorous respect for its particularities"[40] provided a persistent battle-cry of resistance to efforts to submit the discipline to cost-controls, external evaluations, or evidence-based practice standards. As a congress of psychiatric unions noted in a 2012 communique, the discipline had:

> A strong specificity…The absence of a consciousness of troubles, the difficulty of establishing a therapeutic alliance, the alteration of 'free choice'…the impact on the entourage and more broadly the social world, which raises the question, for the patients who are not treated, of risk…[41]

Even my informants who were not psychiatrists evoked these characteristics of the mentally ill to explain why psychiatry could never be seen as a "discipline like any other" (Figure 0.5).

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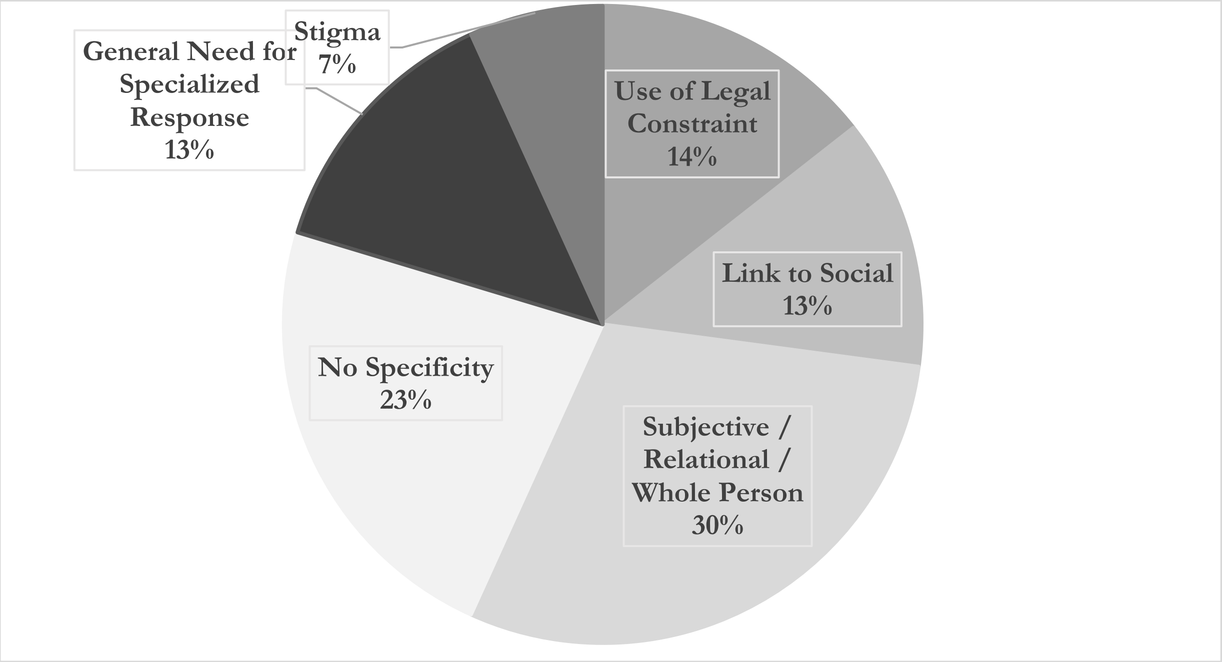
[39] If anything, the principles of the *secteur*—particularly around universal access and continuity of care between the hospital and community—were being extended to the French health system in general (Féry-Lemonnier 2014).

[40] Demay, *Une voie française.*

[41] L'Intersyndicale de Défense de la Psychiatrie Publique. 2012. *Livre Blanc de la Psychiatrie Française.* Paris, France: 6.

Figure 0.5: Specificity of Psychiatric Discipline / Mental Illness



Source: Interviews with 118 French professionals and

French psychiatrists' insistence that their discipline is "different" is, in a sense, factually true. Not only do they have a peculiar competency to impose treatment involuntary, psychiatry also maintains responsibility for many of the administrative functions it held in the asylum. A 1972 government directive set out the expansive responsibilities of the public psychiatrist:

> The doctor at the head of the *secteur* has the responsibility for a team composed of other doctors, social workers, psychologists, nurses, etc. Beyond treatment, this doctor, helped by the team, must ensure connection with all those who can contribute to the re-adaptation and social reinsertion of the sick.[42]

The extensive role of the psychiatric *secteur* as both a health and a social intervention thus carried over to the people operating it. The "unity of actions" of the sector and ultimately the "unity of the sick person" (Thuilleaux 2005:92) were to be guaranteed by the centralizing, managerial role of public psychiatrists. As such, *secteurs* would develop "therapeutic work, therapeutic lodging, clubs for patients…but everything therapeutic. The psychiatrist considers all the dimensions of the person's life, but with a therapeutic end…all about, 'my patient,'" one researcher explained (Interview, 2/25/16).

Secure in both its legal and administrative functions, French psychiatry has arguably steered away from the more extensive aspirations of their American counterparts. Although some advocates saw the missions of "prevention" and "screening" inscribed in *sectorisation* as an injunction to go into the community to aggressively search for new patients (see Kapsambelis 2010; Martin 2000), most *secteur* psychiatrists saw their role as, above all, treating "the heaviest psychotics" (Interview, 5/13/16). The contemporary French psychiatric profession has been remarkably reticent to expand its jurisdiction, whether by evaluating risks to "psychic health" that would justify an abortion in the

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[42] Ministère de la santé publique. 1972. *Circulaire N° 413 du 14 mars 1972 relative au règlement départemental de lutte contre les maladies mentales, l'alcoolisme et les toxicomanies*. Paris, France.

1970s (Ayme 1995:259), joining with victims of trauma to have PTSD recognized as an illness (Fassin and Rechtman 2009:152), or turning hyperactivity among children into a medical problem (Vallée 2009).[43]

This sense of psychiatry's narrow medical mission was tied to the particular trajectory of psychoanalysis in France. Initially rejected as a foreign imposition (Ehrenberg 2010:173; Scull 2015:326), psychoanalysis entered French medicine through the work of Jacques Lacan: "Just as Freud had given hysteria its patients the nobility of endowing it with a full-fledged existence as an illness, so Lacan, forty years later, gave paranoia, and more generally psychosis, an analogous place within the French movement" (Roudinesco 1990:114–15). So understood, psychotic patients were not just the most in need of public protection, but also, as many psychiatrists confided to me, the most interesting.

The idea that the *secteur* was at any point "treatment at the level of 70,000 inhabitants, plus psychoanalysis" (Ayme 1995:12), as one public psychiatrist joked in his biography, is easily overstated. Plunging the depths of the unconscious was something French public psychiatrists did part time in their private *cabinets*. Nor, as some in the ministry insisted, was psychoanalysis a rigid doctrine practiced to the exclusion of other approaches.[44] Instead, my informants explained that their psychoanalytic training was a reminder to pay attention to the inner life of their patients and to be skeptical of diagnostic categories constructed around a vision of mental illnesses as clusters of symptoms or behaviors (Iftimovici 2017). In fact, on the ground, most of my informants explained that the mission of the *secteur*—to care for *all* the *malades* in a given geographic area—required *secteur* teams to be polyvalent. As some of the earliest advocates for the *secteur* wrote in 1965, "We think that the general directive of the *secteur* to ensure continuity of care for all *malades mentaux* sent to the public service should not crystallize around a single doctrine of universal and rigid principles" (Bernard et al. 1965:461).

This totalizing view of the *secteur* run by the jack-of-all-trades psychiatrist treating *malades* whose entire social identity was their illness was under attack from the state administration and by France's patients' and parents' movements. The person in charge of psychiatry in the ministry articulated:

> You still have those who say that the *secteur* knows how to do everything / should do everything / can do everything. It can occupy itself with the dysfunctioning connection between a mother and baby, the psychiatry of the elderly, it knows how to do cognitive remediation, cognitive behavioral therapy, psychoanalysis, post-traumatic stress, anxiety and depression… The *secteur* knows how to find employment and lodging. Except that today it does not know how to do everything, it doesn't have the means to do everything, so it's time for it to work with the rest of the world (Interview, 5/10/16).

The three parts of this dissertation examines how the jurisdiction of public *secteur* psychiatry was indeed constricting. The administration of the health system wanted to submit psychiatry to the rationalization and budgetary austerity imposed on the rest of medicine. The disability system sought to take charge of aid in daily life, housing, and employment for the chronically ill. And the judiciary

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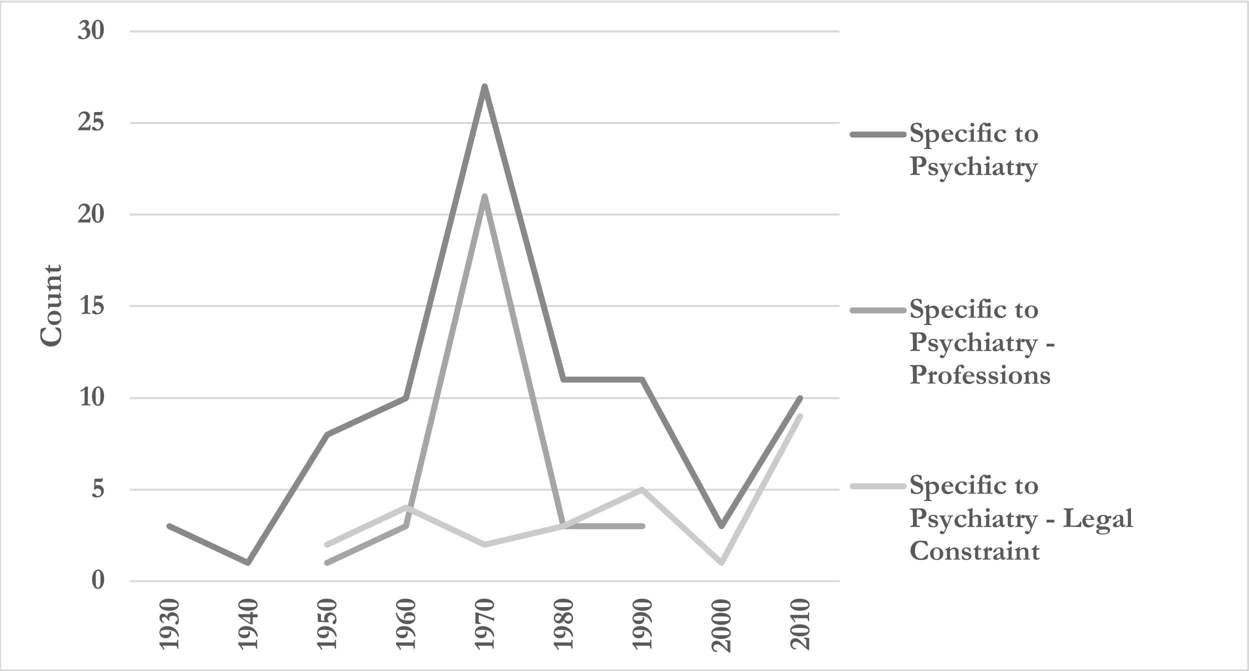
[43] This is quite a break from the interest of 19th century French psychiatry in determining responsibility for crime (Foucault 1981) or protecting the nation from "degeneration" (Nye 1984). A contemporary counter-example to my argument comes from Lloyd's (2008) analysis of the role of (presumably private) psychiatrists in encouraging the spread of the diagnosis of "social phobia."

[44] I leave out here a discussion of the persisting prevalence of purely psycho-analytic approaches in French private psychiatry (Kovess-Masféty et al. 2005; Younès et al. 2005) and the enormous polemics around the use of psychoanalysis in the treatment of autism (Chamak 2008; Jaeger 2012).

Figure 0.6: Legislation Specific to Psychiatry in France



Source: Government *circulaires, décrets, and arrêtés* mentioning "psychiatry" or "mental health."

was supposed to curtail the discipline's autonomous decision-making over involuntary hospitalization.

Institutionally, though, French psychiatry was well-positioned to weather these challenges. With their statute as hospital practitioners, *secteur* psychiatrists had a prestigious title tied to a well-funded institution (budget cuts notwithstanding). Their special mission was inscribed in law and, after a dip, the state was producing more official directives and laws specific to psychiatry (Figure 0.6). They faced no strong competition from other disciplines: French psychologists are not reimbursed by national insurance, social workers have no clinical training, and nurses are firmly below them in the medical hierarchy.[45] Moreover, despite the "catastrophic demographics of psychiatry" (Interview, 5/12/16) as the generation of '68 departed for retirement, France maintains a density of psychiatrists among the highest in the Western world (Figure 0.7).[46] Furthermore, although psychiatrists were famously among the worst classed on the national exams for placement into medical specialties,[47] the fact became less striking when I realized how many of my interviewees stated they were more interested in reading philosophy than neurology.

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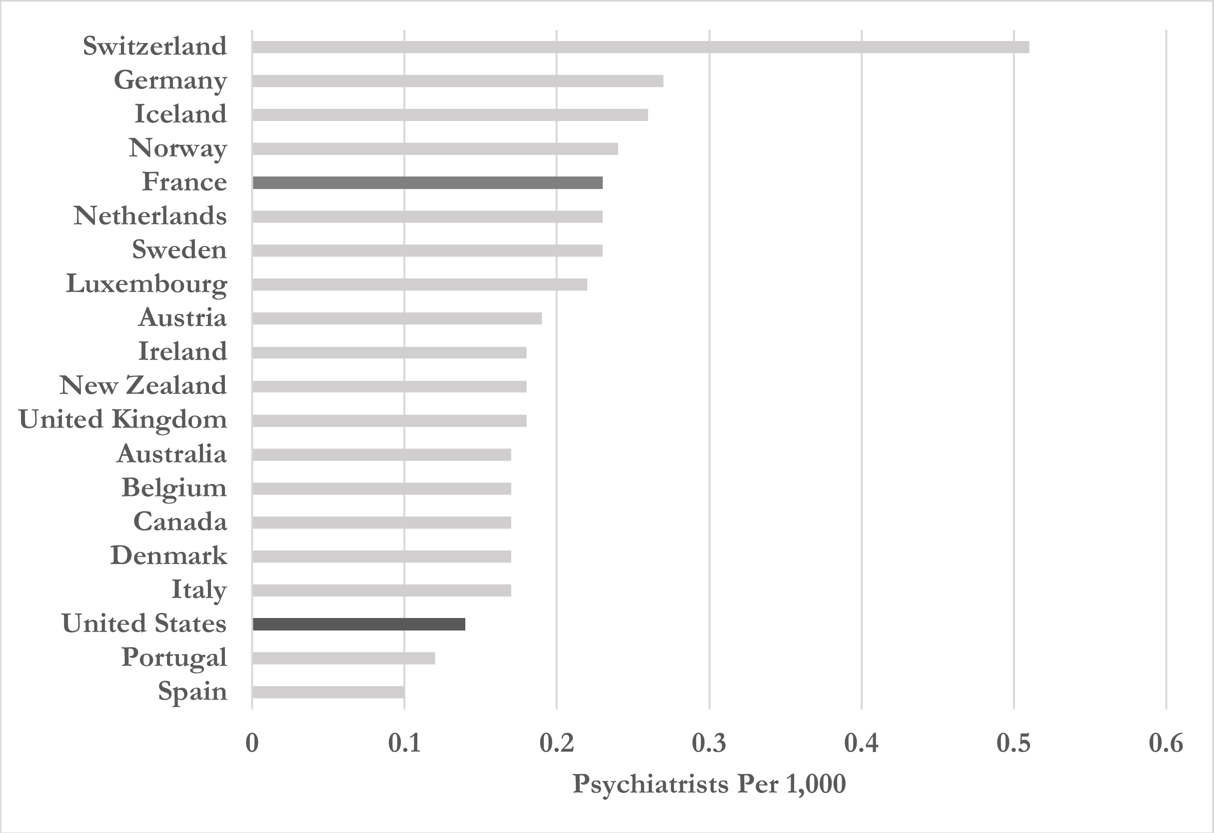
[45] The lowly status of French psychologists in the health system is discussed in Biliard (2001) and Carson (2007) (although at the time of writing the Regional Health Agency of Ile-de-France was experimenting with reimbursing a limited number of sessions with psychologists). Hardy-Baylé, *Donnés des preuves,* and Verdes-Leroux (1978) both discuss the more narrow competencies of French social workers. My reference to the placement of nurses in the *secteur* hierarchy is not intended to diminish their often much deeper relationships with *secteur* patients and unique *savoir-faire,* until 1992 formalized with a specialized diploma for "nurses of psychiatric *secteurs*" (see Jaeger 2012).

[46] Although psychiatry was expected to decline by 8.1% between 2009 and 2030, it is not even in the top ten disciplines facing the largest demographic decline. Attal-Toubert, Ketty and Mélanie Vanderschelden. 2009. *La démographie médicale à l'horizon 2030: de nouvelles projections nationales et régionales*. N° 679. Paris, France: Direction de la recherche, des études, de l'évaluation et des statistiques.

[47] Laforcade, Michel. 2016. *Rapport relatif à la santé mentale*. Paris, France: Ministère des affaires sociales et de la santé: 35.

Figure 0.7: Density of Psychiatrists



Source: OECD Health Stat.

In short, public psychiatry had an ethos and identity closely tied to the institutions within which they labored, the *secteur* policy with which they invariably saw flaws but to which they were ultimately attached, and the psychotic patients to which they felt a special duty. As Henry Ey, a founding father of the *secteur,* put it in his letter of retirement:

> I hope that young, rising generations [of psychiatrists] keep the concern of…the services which, by their vocation, they are obliged to direct. It is only through a consciousness of their own responsibilities in the institution that they [the institutions] can attain their goal: the liberation of the *malades* from their malady (qtd. in Ayme 1995:27).

Even in the face of a perceived incoherence or indifference of national policy, there was nonetheless a clear and consistent organization of the mental health system. The French repertoire of policy-making closely linked a specific type of person (the *malade mental*) with a profession (psychiatry) and an institution (the asylum, extended to the *secteur*) with complete jurisdiction over them. These responses flowed in part from a conceptualization of the mentally ill as chronically *malade*, requiring a response that was above-all medical, but who required an extra layer of both protection and control that separated them from other sick people.

The U.S.: Atomized System, Autonomous Subjects

Asylums and Assistance

Despite common portrayals of the United States as at the forefront of the medicalization of social problems (see, e.g., Becker 2013; Castel, Castel, and Lovell 1982; Conrad 2007), the status of asylums as medical institutions, psychiatrists as doctors, and the severely mentally disordered as patients have been consistently more parlous than in France. Pinel's model of "moral treatment" was an inspiration for asylum builders in the U.S. (Scull 1989), but its most famous advocate was not a doctor, but a philanthropist and lay advocate, Dorothea Dix, who exhorted the Massachusetts legislature, "Become the benefactors of your race, the just guardians of the solemn rights you hold in trust. Raise up the fallen; succor the desolate; restore the outcast; defend the helpless; and for your eternal and great reward, receive the benediction" (Dix 2010 [1843]:123). The absence of a reference to "treatment" is notable. The earliest asylums in the U.S. emerged from the "Quaker traditional of benevolence" rather than medical currents; legislatures declared themselves to be providing for "insane citizens" rather than patients (McGovern 1985:41,43).

President Franklin Pierce vetoed Dorothea Dix's 1854 Bill for the Benefit of the Indigent Insane, which would have sold federal land to finance asylums (Grob and Goldman 2006:4). He "acknowle[d] the duty incumbent on us all…to provide for those who, in the mysterious order of Providence, are subject to…disease of body or mind" but cautioned that the bill would assume a responsibility to "provide hospitals and other local establishments for the care and cure of every species of human infirmity, and thus to assume all that duty of either public philanthropy or public necessity to the dependent, the orphan, the sick, or the needy which is now discharged by the States."[48] The debate was not, as in France, over the relative primacy of care and control, but about responsibility for assistance in a context where colonial systems of provisioning of the mad in local communities were breaking down (Rothman 1971). Battles over cost-shifting between levels of government and types of institutions made an early appearance, and the American policymaking repertoire has frequently confined the mental health system to the same underdevelopment as the rest of the welfare state.

Psychiatry was a late arrival in these debates. Advocates of treating the mad by removing them from their habitual environment and placing them in a structured institution explicitly contrasted their approach with the harmful purges and bleedings imposed by mainstream American doctors (Scull 1989:102). But while "Medical Superintendents for the Insane" "did not originate the concept of institutionalization," they subsequently "embraced it and molded the details of asylum design and management" (McGovern 1985:ix). They aggressively lobbied state legislatures and succeeded in making provision for the insane a precocious field of American social policy (Hollingsworth 1992; Katz 1996). Over time doctors gained jurisdiction over certifying the appropriateness of placements, which were by default involuntary, and thus gained authority over what was once province of juries and judges (Appelbaum and Kemp 1982; Dwyer 1988).

Given contemporary anxieties over the neglect of the mentally ill, it's hard to overstate how extensive the public mental health care system was by the mid-20th. After a second wave of hospital construction impelled by the progressive movement, asylums by 1923 held more inmates than all other custodial institutions in the U.S. combined (Sutton 1991:666). During the New Deal, the federal government even chipped in to construct more psychiatric hospitals (Hoffman 2012:19). In the 1950s, 88% of all mental health treatment and 98% of institutionalized patients were in the public system (Grob and Goldman 2006:14); two thirds of psychiatrists worked there (Grob 1991). Hospitals were one of the largest line-items in state budgets, peaking at 33% in New York (Grob 1994). When the asylum population crested at 550,000 in 1955, half of all hospital beds in the U.S.

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[48] Pierce, Franklin. May 3, 1854. "Veto Message." Retrieved April 18, 2019 (https://lonang.com/library/reference/1854-pvm/).

Table 0.1: Community Care Policies in the U.S. and France

"Special Message to Congress" (1963) – United States	***"Circulaire relative to the fight against mental illness" (1960) – France***
"Mental illness and mental retardation are among our most critical health problems."	"At this moment the role of mental illness among the social scourges appears every day more worrisome."
"we must seek out the causes of mental illness…and eradicate them… 'an ounce of prevention is worth more than a pound of cure.'"	"a goal is to begin care for the mentally ill earlier, with a greater chance of success, and to bring to existing ill support that reduces the risk of recidivism."
"Reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability."	"We should not lose sight that the majority of the mentally ill pose medical-social problems that are not fixed by hospitalization."
"[CMHCs] could move [patients] without delay or difficulty to different services—from diagnosis, to cure, to rehabilitation—without need to transfer"	"Each sector will assure…the indispensable continuity between screening, treatment…and rehabilitation"

were for psychiatric patients.[49] Treatment in these facilities, as in France, was *de-minimis*: as Erving Goffman (1961:312) documented, inmates were expected to profess faith the efficacy of psychiatric ministrations, but only 100 out of 7,000 received psychotherapy in a given year. Asylums were the dustbins into which those excluded from the rest of America's meager welfare state were swept.

Separating Hospital and Community Care

World War II was also a turning point for mental health care in the U.S. Military psychiatrists showed that with brief psychotherapy they could rapidly and effectively treat shell-shocked soldiers, a demonstration that enhanced the discipline's prestige and led to the reassignment of other doctors to mental medicine (Grob 1991:17–21). In fact, after millions of draftees were turned away for neuro-psychiatric reasons, psychiatrists could credibly claim that veterans were "no worse off, in fact sometimes better off, than millions of their fellow citizens with minor neuropsychiatric disorders who have not had the benefit of a psychiatric service like that of the U.S. army" (qtd. in Staub 2011:22). At the same time, conscientious objectors assigned to work in state hospitals during the war began to report on conditions that, if not leading to a wholesale "massacre of the mad," were bad enough that the facilities began to be christened "the shame of the states."

That de-institutionalization would go much further in the U.S. than in France was not preordained. While anti-psychotics were first introduced at Sainte Anne's in Paris in 1952, New York State was the first to deliver them *en masse*. In the immediate term, though, medications seemed like the redemption rather than the death knell of the state hospitals, because they gave new life to the idea that they were curative rather than custodial institutions (Braslow and Starks 2005; Gronfein 1985; Metzl 2009). A Special Committee on Mental Illness in New York State (1962:3–4) reported:

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[49] Geller, Jeffrey. 2019. "The Rise and Demise of America's Psychiatric Hospitals: A Tale of Dollars Trumping Decency." *Psychiatrics News*. Retrieved April 18, 2019 (https://psychnews.psychiatryonline.org/doi/abs/10.1176/appi.pn.2019.3a36).

> The bars are disappearing—from most of the windows. The wards are quiet—save for an occasional moaning or outburst of shouts. The harsh words—asylum, lunatic, straitjacket—are dying out, as new ways of thinking replace the old. In mental hospitals in New York State, as elsewhere throughout the world, the last ten years have been years of revolution, the revolution against violence…For the first-time mental patients everywhere…can be treated like human beings with a disease.

At least for a moment, it seemed intuitive that "rapid…admission to mental hospitals" would be "good" and "helpful" for most of these "human beings with a disease" (Special Committee to Study Commitment Procedures 1962:54).

The policy announced by President Kennedy in his 1963 message to Congress shared with the *circulaire* on *sectorisation* an assertion of the under-appreciated prevalence of mental disorders, the value of early intervention, and the need for continuity of care (see Table 0.1).[50] The Act that followed it mandated that the new federally-financed Community Mental Health Centers (CMHCs) provide comprehensive prevention, diagnosis, treatment, and rehabilitation of mental illness[51]—all themes that anchored *sectorisation* as well. The policy "received national publicity and aroused little overt opposition" (Grob 1991:227). Indeed, while the French *circulaire* was, at the time, of interest to only a small cadre of militant psychiatrists and their allies in the ministry, for a brief moment at the start of the 1960s de-institutionalization was "a high priority agenda item at the highest level of government" (Mechanic and Rochefort 1990:303).

Kennedy's speech and the policy that flowed from it was rooted in a comparatively more optimistic view of the prognosis of mental illness. When he stated that new medications had "rendered obsolete the traditional methods of treatment which imposed upon the mentally ill a social quarantine, a prolonged or permanent confinement in huge, unhappy mental hospitals"[52] he did not propose making those hospitals smaller and happier. The Medicaid Act of 1965 included an "exclusion" that barred federal funds from going to "Institutes of Mental Disease." "IMDs" are specialized psychiatric institutions with more than sixteen beds—or, to put it differently, state hospitals. States responded in obvious fashion: hospital censuses had started falling by 1.5% per year in 1955, but plummeted 8% per year after 1965 (Frank and Glied 2006:95).[53] The shift in financing from inpatient and residential treatment towards outpatient providers and medications has been inexorable, at least until recent years (Figure 0.8)

Indeed, the new CMHCs "provided a golden alibi to those who favored cutbacks in the state hospital budgets" (Castel et al. 1982:88). In truth, a 1977 report from the Comptroller General found that these facilities, with no formal linkage to the state hospitals, "attracted a new type of patient who was not very ill and not a candidate for hospitalization in a state institution."[54] Following a common pattern, Congress in 1978 passed legislation mandating the CMHCs treat "special populations" like children, the elderly, and substance users; the result was a further dilution of their already tenuous commitment to the severely mentally ill. In any case, the expansive social

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[50] Kennedy, John F. 1963. *Special Message to the Congress on Mental Illness and Mental Retardation.* Washington, DC: Office of the President of the United States.

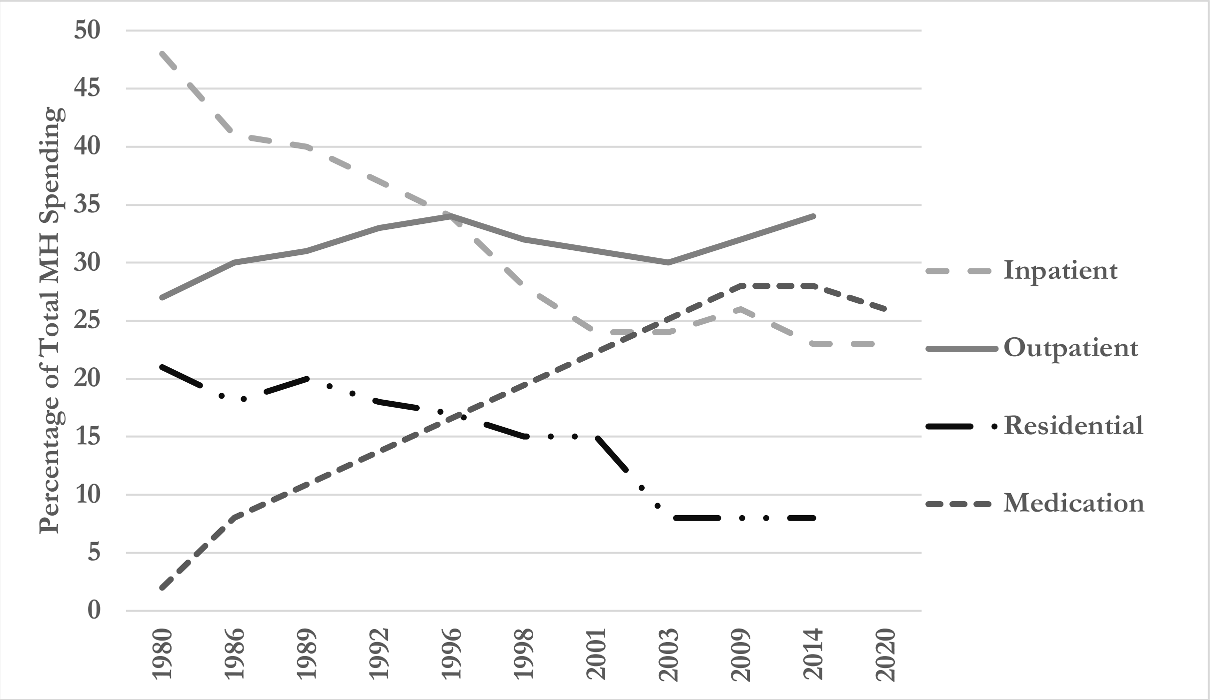
[51] United States Congress. October 31, 1963. *Mental Retardation Facilities and Community Mental Health Centers Construction Act.* Retrieved April 19, 2019 (https://history.nih.gov/research/downloads/pl88-164.pdf).

[52] Kennedy, *Special Message to the Congress.*

[53] The most rapid declines were for the elderly, for whom Medicaid opened up a whole need array of nursing facilities.

[54] Comptroller General of the United States. 1977. *Returning the Mentally Disabled to the Community.* Washington, DC: 73. The point was reiterated by the Steering Committee on the Chronically Mentally Ill. 1980. *Toward a National Plan for the Chronically Mentally Ill.* Rockville, MD: U.S. Department of Health and Human Services. Torrey (2013:75) claims that only 5% of CMHC clients were former state hospital patients.

Figure 0.8: U.S. Mental Health Spending by Type (1986-2020)



Source: Substance Abuse and Mental Health Services Administration. 2014. *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020*. HHS Publication No. SMA-14-4883. Rockville, MD: U.S. Department of Health and Human Services.

mission embraced by the CMHCs (discussed in the next section) made them a target for conservatives, culminating in the effective termination of federal support for a national mental health system under Reagan (Carpenter 2000; Grob and Goldman 2006).

The drastic decrease in state hospital beds (90% since the 1970s)[55] could easily lead to an exaggerated sense that the psychiatric hospital has disappeared from the treatment landscape. De-institutionalization in the U.S. was actually much shallower than in Italy, for example, which has only one-third as many beds relative to the population (Dumont and Dumont 2008). Across my field sites, I found that hospitalization remained a key moment in the trajectory of people with severe mental disorders (even if it served for acute stabilization rather than long-term care). Yet the contemporary role of hospitals has been largely ignored in public policy,[56] which continues to suggest that effective community treatment would render them unnecessary.[57] One psychiatric medical student in New York City lamented the fragmented system that resulted from the deliberate excision of hospitals from the community mental health system:

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[55] Lutterman, Ted, Robert Shaw, William Fisher, and Ronald Manderscheid. 2017. *Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014*. Alexandria, VA: National Association of State Mental Health Program Directors: 29.

[56] President Bush's commission commented that hospitals were an "important segment of the health care delivery system" but made few recommendations about them other than calling for more data. President's New Freedom Commission, *Achieving the Promise*: 77.

[57] New York City's billion-dollar "Thrive" initiative emblematic of a representation of hospitalization not as an occasionally necessary evil, but a systems failure. The City of New York. 2015. *ThriveNYC: A Mental Health Roadmap for All*. New York: Department of Health and Mental Hygiene.

> The system would work if there was a real connection [from hospitals] to outpatient care. The therapist could accompany someone to the hospital and talk to a clinician. Now, their discharge plan is a list of clinics that are first come first serve; we don't even know if they're accepting new clients (Interview, 1/11/17).

Under Carter, a joint commission on mental health actually proposed that the U.S. integrate inpatient and outpatient care in a manner explicitly modeled on France (Gittelman 2009); in 2017, this medical student's vision seemed like a pipe dream.

American Psychiatry: Paradoxical Professional Precarity

Even compared to other Western countries, in the United States and France doctors are politically influential and culturally powerful (Hassenteufel 1997; Immergut 1992; Wilsford 1991). But, as Paul Starr (1982:6) observes, "hardly anywhere have doctors been as successful as American physicians" in maintaining their autonomy and professional dominance of the health system. By some renderings, American psychiatrists are for their part a "new priestly class" (Nolan 1998:7) who play an "increasingly dominant role in molding the American mind, to a degree surely unparalleled in any other nation" (Porter 1989:190; see, also, Carson 2007; Ehrenberg 2010; Rose 2006b). Narratives on the globalization of American psychiatry have concurred that the specialty, Diagnostic and Statistics Manual in hand, has been uniquely ambitious in colonizing the human psyche (Kutchins and Kirk 1997; Rose 2006a; Watters 2011).

If its overall reach is expanding, though, the discipline's perch at the core of America's mental health system, and its role in the treatment of the most severe mental disorders, is remarkably precarious. This might seem like a surprise. Psychiatry in the U.S. has never had the firm legal basis granted by the law of 1838 in France (Castel et al. 1982). Nonetheless, American psychiatry emerged from World War II celebrated for its role in restoring soldiers to health, rather than discredited through its association with execrable asylum conditions. In the post-war period, "the prestige of psychiatry reached unprecedent heights" and "both the number and the proportion of medical students entering the specialty increased rapidly" (Grob 1991:273). The psychiatrists in the community mental health movement were "grandiose" (Torrey 2013:67) in their claims to be able to use psychoanalysis to make sense of and treat a host of problems, from racism to urban riots, authoritarian personalities to family dynamics (Ehrenberg 2010; Metzl 2009; Staub 2011). The *secteur* psychiatrists in France shared this optimism about the power of new community-based treatment approaches, but their vision was still largely that they were treating "the mentally ill," not society as a whole. While French psychiatrists were struggling to have both their legitimacy and specificity as doctors recognized, American psychiatrists seemed to be transcending "medicine" entirely.

The weakness of contemporary American psychiatry, at least within the public system, stems from the particular strategies it adopted in response to its critiques and failings. In "liberating" itself from the "old bastion of the asylum" (Castel et al. 1982:298), psychiatry abandoned the "basic framework of professionalism" (Starr 1982:72) that guaranteed them an institutional role. In the community, the fundamentally contested boundaries of mental illness, inconsistency of psychiatric diagnoses, and lack of consensus about treatment were in the open (Craciun 2016; Ennis and Litwack 1974; Lakoff 2005; Mechanic, McAlpine, and Rochefort 2014; Scheid 2004). As Grob and Goldman (2006:24) observe:

> Claims about the efficacy of community care and treatment rested on extraordinarily shaky foundations. The empirical data to support the claim that outpatient psychiatric clinics could identify early cases of mental disorders and also serve as alternatives to traditional mental

> hospitals were virtually non-existent. Claims of accomplishment and effectiveness rested on ideology and faith, and were rarely, if ever, accompanied by empirical data.[58]

The expansive aspirations of post-War psychiatry left it open to attacks from the left that it was engaged in a project of normalization and social control and from the right that it had abandoned medicine for social justice. Perhaps most importantly, as Goffman (1961:357) pointed out, if psychiatry was not treating illnesses but helping regular people adapt to society, there was no clear reason why that function should be filled by doctors as opposed to other (cheaper) professionals—or even lay people (see, also, Abbott 1988; Grob 1994; Horwitz 2011).

The well-documented response of professional psychiatry was to fall back on the discipline's medical foundations and the key power it granted to them but not psychologists and social workers—the power to prescribe. The DSM-III, released in 1980, was the "official death announcement" (Staub 2011:8) for socially-oriented psychiatry in the U.S., replacing fuzzy psychoanalytic categories with diagnoses that were supposed to represent discrete, biologically-based conditions (Cohen 1993; Horwitz 2001; Strand 2011). In large part, psychiatry's attempt to re-establish itself within the medical field has also meant abandoning the still distinctive arena of public mental health. The most severely ill patients, of course, are neither lucrative for private practitioners nor, as a result of their chronicity, likely to buttress a discipline's status as effective healers (Scull 1981:750). In the 1950s, a shrinking proportion of psychiatrists worked in state hospitals; by the 1980s, they were exiting the community mental health clinics as well (Grob 1991; McGovern 1985).

Although the American Association of Community Psychiatrists continues to provide a professional home for psychiatrists focused on treating the severely mentally ill, there is no equivalent to the French public psychiatrists' unions or their valorization of treating "real *malades*." As one New York psychiatrist involved in training community clinicians told me: "Psychiatry is nothing in the public system. There are many psychiatrists in New York, but most of them aren't even taking insurance. We're not running anything—that's social workers and psychologists" (Interview, 1/16/17).[59] As she went on to explain, the nature of psychiatrists' work—focused on "med management" (W. C. Torrey, Griesemer, and Carpenter-Song 2017)—marginalized them because "much of what we do for severe mental illness is not medical, but social" (see Chapter 1). Another psychiatric professor told me:

> In community mental health, psychiatrists—the most expensive personnel—were relegated to the one thing they were permitted to do that no one else could do, which was the prescription of medication. You have psychiatrists who are responsible for 500 or more patients, whose days consist of 15-minute sessions, and you can squeeze a lot of those into an 8-hour day. That's what their role became. Not diagnosis, not participation in the broader management of the patient, and certainly not psychotherapy… Not even leader of the team. A member of the team. In some senses equal with everyone else, and in some senses less equal, because they know the patient so much less well, because they see the patient 15 minutes every two months, as opposed to social workers or master's or even bachelor's level therapists. That's the unhappy story of the public mental health sector, which has driven many of the best people out of that work (Interview, 12/14/16).

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[58] As Hasenfeld (1985:662) puts it, the CMHCs were "rich in ideology and poor in effective technologies."

[59] Another marker of the low status of American public psychiatry was the extraordinarily high prevalence of foreign doctors, many from developing countries, in public hospitals I observed in New York (see Jenkins 2018). I note this more as a reflection on the importance accorded to the severely mentally ill by our medical system, and not the quality of these doctors themselves.

To a much greater extent than in France, the perceived crisis of public mental health was also a crisis of psychiatric authority. As one lawyer representing the mentally ill told me, "Psychiatry can just give my clients two weeks of synthetic sanity, which doesn't necessarily change anything" (Interview, 12/13/16). With medications called into question, and the needs of the severely mentally ill defined in non-medical terms, psychiatric intervention in the public system has a precarious legitimacy.

The retreat of psychiatry has not, of course, left a jurisdictional void: many of the managerial roles and responsibilities for helping with employment, income, or housing assumed by French psychiatrists are filled by growing numbers of clinical social workers, whose training is arguably better adapted to these tasks anyway (see Scheffler and Kirby 2003). Psychiatrists still have enormous power in their ability to hospitalize people involuntarily. But this fragmentation of professional roles reproduces the fragmentation of policy related to mental health writ large. Post-1963, there has been almost no federal legislation and a paucity of policy initiatives on the topic. As a 1977 report outlined, the U.S. has "rel[ied] on the many social, welfare, and other programs that affect general population target groups, such as the poor, the aged, children, or the disabled, to accomplish deinstitutionalization without any central guidance, management, or focus."[60] Just as the main policies affecting the mentally ill might be about health in general, disability, or criminal justice, the primary actors intervening in their lives are as likely to be primary care doctors, social workers, or police officers. Their social identities as "mentally ill" are both deliberately effaced by attempts to render mental illness an "illness like any other" and inadvertently in competition with overlapping labels of them as poor, disabled, criminal, or addict.

Epidemiology

Earlier versions of this project incorporated into its comparative set up epidemiology on the prevalence of mental illnesses and surveys on rates of medication use or visits to mental health practitioners. I have largely stepped back from doing so, for three reasons. First, my ethnographic observations make me skeptical of whether key diagnostic categories are applied to the same people in each country. Second, the data are often hopelessly inconsistent and usually rely on self-reported feelings of distress that create an inflated picture of conditions that few beyond epidemiologists themselves would consider "illnesses."[61] Third, this dissertation is focused more narrowly on severe mental disorders treated in the public sector, a subset usually washed out in studies of mental illness in the population in general.

The most thorough attempt to create reliable cross-national data on the prevalence of mental illnesses is the World Mental Health Survey, carried out between 2001 and 2002 (Üstün and Kessler 2008). The data point to some interesting contrasts between France and the U.S. and between the two and the other developed countries surveyed. For example, the U.S. and France have the highest and third highest lifetime / 12-month prevalence of any mental disorder (47.4/27.0%[62] and 37.9/18.9%, respectively, versus a developed world average of 24.9%/14.3%—see Table 0.2).[63] On the other hand, overall treatment prevalence is fifty percent higher in the U.S. than France (17.9% versus 11.3%) in the last year and twice as high for specialty mental health services (8.8% versus

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[60] Comptroller General, *Returning the Mentally Disabled to the Community*: 26. This point is also made by Frank and Glied (2006), Cook and Wright (1995), and Torrey (2013).

[61] This critique of whether "prevalence" indicates "need" is made by Mechanic (2003)

[62] The U.S. Substance Abuse and Mental Health Services Administration put the number lower, at 17.0% in the last year, in its 2012 report. Substance Abuse and Mental Health Services Administration. 2012. *Behavioral Health United States. HHS Publication No (SMA) 13-4797*. Rockville, MD: U.S. Department of Health and Human Services.

[63] The most striking *difference* between the two countries was the much higher prevalence of substance use disorders in the U.S. (14.6/3.8%) than in France (7.1/1.3%).

4.1%).[64] Strikingly, a higher proportion of people with *severe* mental illness receive treatment in the U.S. (59.7% of this subpopulation)[65] than in France (41.8%), though treatment in the latter is more likely to be "minimally adequate" (Wang et al. 2007).

Insofar as we take these (dated) data at face value, they offer a few points of interest for this study. For one, France and the U.S. might be considered strategic cases because the prevalence of mental illnesses is particularly high. At the same time, treatment is much more widespread in the U.S. than in France, which belies what we might predict given France's more universalistic health system. But this in consistent with my claims in Chapter 1 that the U.S. system is "extensive"—identifying and treating along a spectrum of mental health—and the French system "intensive"—focusing on a narrow band of "real *malades*." These differences are somewhat consistent with more recent data showing that the most common treatment for mental illness, anti-depressants, is far more prevalent among U.S. adults than in France (12.7% versus 5.0%[66], with a rich Western average of 6.6%), although the gap narrows when anxiolytics like Valium are included.[67] The lower treatment rates among people with *severe* mental disorders in France is surprising and inconsistent with the finding of greater penetration of the public system (see Figure 0.10), although the finding that treatment in France is more adequate, particularly in terms of duration and consistency, certainly fits well with my results.

But what can epidemiology tell us about the prevalence of *severe* mental disorders? Despite the common trope that around 1% of any population suffers from schizophrenia,[68] systematic reviews of the scientific literature suggest the lifetime prevalence is closer to .4% (Saha et al. 2005). For Table 0.3, I focused on the prevalence estimates cited most frequently in official government reports in the two countries. They show similar rates of BiPolar Disorder and Schizophrenia, although the raw numbers given for the latter are particularly inconsistent in each country.[69] The U.S. shows higher rates of depression, but even "major" depression can span "severe" to "mild."[70] Most interestingly, U.S. government actors frequently state that 4.0% of the adult population has a "severe" condition, while French reports say half that.[71] This point is consistent with the lower proportion of French people being administratively recognized as having a disability based on mental illness (Figure 2.1). One final measure of the severity of mental health problems is the suicide rate, slightly higher in France (but falling) than the U.S. (where it is rising).[72]

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[64] These numbers for the U.S. are somewhat consistent with what Mojtabai and Jorm (2015) report for 2011-2012: 13.7% of adults received some mental health treatment, and 7.9% consulted a specialist.

[65] A 2017 update for the U.S. put the figure for treatment access by people with severe mental illness at 65.3% Substance Abuse and Mental Health Services Administration. 2017. *Behavioral Health Barometer United States, Volume 4*. HHS Publication No. SMA–17–BaroUS–16. Rockville, MD: U.S. Department of Health and Human Services.

[66] Moreover, according to Gusmão et al. (2013), France has one of the slowest rates of growth for anti-depressant use.

[67] See Pratt, Laura A., Debra J. Brody, and Qiuping Gu. 2017. *Antidepressant Use in Persons Aged 12 and Over: United States, 2011-2014. NCHS Data Brief.* Rockville, MD: National Center for Health Statistics; for France, OECD Health Stat.

[68] This figure was most notably embraced by the French parents' movement, UNAFAM, in calculating the number of people with a "psychic handicap" as 600,000, or 1% of the French population.

[69] In France, I found numbers ranging from 132,000 up to 600,000. In the U.S., the National Institute of Mental Health went from estimating that there were 2.8 million people with schizophrenia to 750,000 in 2017. No new U.S.-based studies had been published to justify the shift. Torrey, E. Fuller and Elizabeth Sinclair. "Hocus Pocus: How the National Institute of Mental Health Made Two Million People with Schizophrenia Disappear." *Treatment Advocacy Center*. Retrieved March 28, 2019 (https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3970).

[70] For depression specifically, the U.S. has the highest prevalence of depression in the last year (8.3%) with France (5.9%) coming in fourth (out of ten) behind New Zealand and Israel (Kessler and Bromet 2013).

[71] I leave out the non-sensical figure from Chevreul et al. (2013) that puts the figure at 15.6%.

[72] Although a French tradition, reaching back to Durkheim (1997 [1897]), treats suicide a social phenomenon separate from mental illness, a division to which many of my interviewees still largely adhered.

As stated earlier, I consider mental disorders "real." I do not, however, think that these different statistics are in some cases more and in some cases less accurately capturing a "real" prevalence of disorders that is out there waiting for a better methodology to capture it. Statistics like these are part of what constitutes the very population of mentally ill persons they measure. The treatment prevalence rates cited are also, for their part, products of different institutional arrangements that make certain individuals visible to medical and political actors as mentally ill.

Table 0.2: World Mental Health Survey

	France	***United States***	***Developed Countries***[*]
Any Mental Disorder (Lifetime / 12-month)[°]	37.9 / 18.9%	47.4 / 27.0%	24.9 /14.3%
Any Treatment (12-month)[♦]	11.3%	17.9%	8.7%
Specialty Treatment (12-month)[♦]	4.4%	8.8%	4.1%
Treatment Prevalence for Severe Disorder (12-month)[♦]	48.0%	59.7%	50.3%
Minimally Adequate Treatment for Severe Disorder (12-month)[+]	57.9%	41.8%	51.3%

* Includes Belgium, France, Germany, Israel, Italy, Japan, Netherlands, New Zealand, Spain, and the United States.

° From Kessler et al. (2009). ♦ From Wang et al. (2007).

+ Minimally adequate treatment was defined as receiving eight or more visits to any service provider, or four or more visits and at least 1 month of medication, or being in continuing treatment at interview.

Table 0.3: Prevalence of Severe Disorders and Suicide

	France	***United States***
Mental Disorder with Severe Impairment[*]	1.6-2.1%	4.0%
Depression (12-month)[□]	5.0-8.0%	8.3%
Schizophrenia[°]	.78-1.0%	.25-1.1%
BiPolar Disorder[♦]	1.2-5.5%	2.8%
Suicide (per 100,000 population)[+]	17.7	15.3

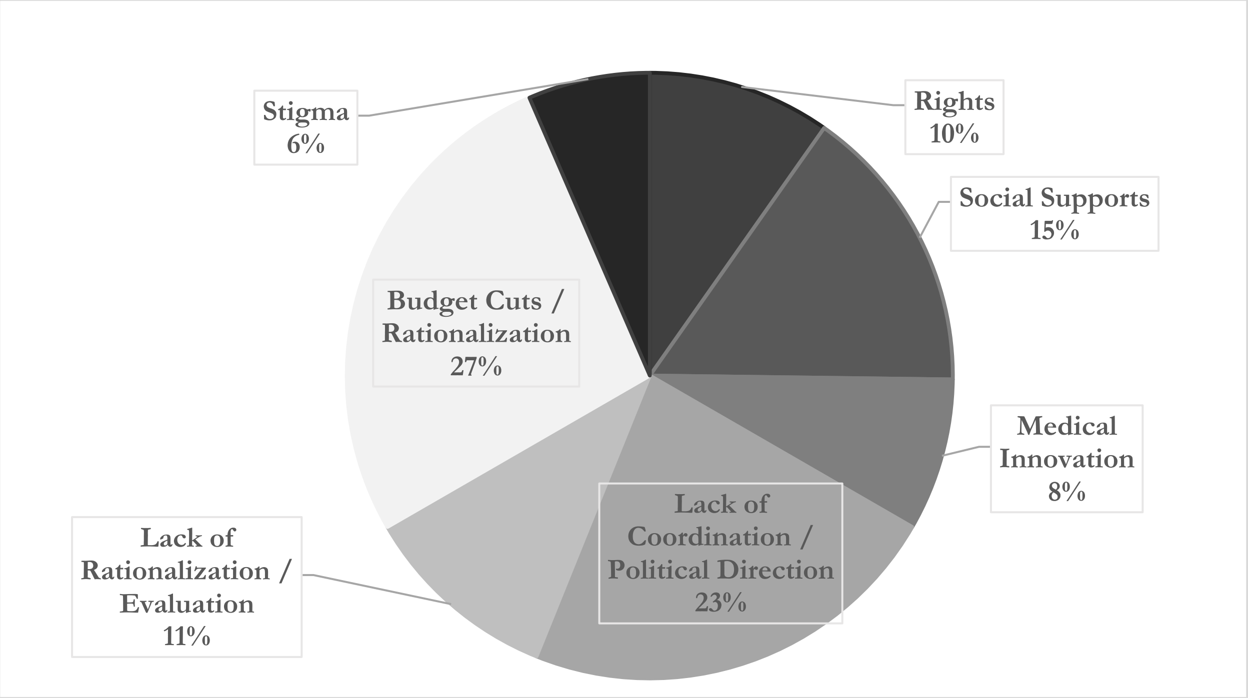
* For France, Chee et al. (2012) and statistics *Affections des longue durée* (2015); for U.S., SAMHSA, *Behavioral Health Barometer*. □ For France, Chee, Christine Chan, François Beck, David Sapinho, and Philippe Guilbert. 2009. *La dépression en France: Enquête Anadep 2005*. Saint-Denis, France: INPES and Lopez, Alain and Gaëlle Turan-Pelletier. 2017. *Organisation et fonctionnement du dispositif de soins psychiatriques, 60 ans après la Circulaire du 15 Mars 1960*. N°2017-064R. Paris, France: Inspection générale des affaires sociales :21; for U.S., SAMHSA, *Behavioral Health United States*.

° For France, Bousquet (2016), Hardy-Baylé, *Donnés des preuves*; for U.S., National Institute of Mental Health. "Schizophrenia." Retrieved July 16, 2019. (https://www.nimh.nih.gov/health/statistics/schizophrenia.shtml).

♦ For France, Lopez and Turan, *op cit;* for U.S., NIMH. "BiPolar Disorder."

+ From World Health Organization. Retrieved July 15, 2019 (who.int/gho/mental_health/suicide_rates_crude/).

Figure 0.9: Central Challenge for Mental Health System (France)



Source: Interviews with 123 French professionals and policymakers

Structure: Three Tensions in Contemporary Mental Health Care

This dissertation examines the institutional structures, policymaking regimes, and cultural conceptions around mental health care described above as they exist in a contemporary context where each system is widely described as being in "crisis." In France, a 2018 editorial by a renowned psychiatrist declared that "public psychiatry has become a hell" [*est devenue un enfer*] and "[its] disaster is unrolling before our eyes."[73] The authors of the book on *Psychiatry: The State of Crisis* summarized the system's failings:

> Inexistence of prevention…lengthening delays for consultations that can extend to nine months, deficient treatment out of conformity with recommendations, excessive use of involuntary hospitalization (92,000 per year), inordinate use of restraints…Although France is known for the quality of its medicine and for its up-to-date health establishments, psychiatry is clearly the exception…Care for these [psychiatric] troubles is unreliable, if not poor (Leboyer and Llorca 2018:12,146).

The most immediate cause of malaise among professionals was budgetary restrictions (Figure 0.9). At the time of my fieldwork, they were living through another wave of attempts by the state to overcome the "impossible regulation of the health system" (Palier 2005:150) which had opened an ever-expanding "hole" in the social security budget. In truth, "austerity" thus far has meant that the growth of the budget for psychiatry had ground to a halt, without actually falling.[74] This was not what professionals on the ground actually felt, however. "We are always losing a bit more of our

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[73] Zagury, Daniel. June 12, 2018. "La psychiatrie publique est devenue un enfer." *Le Monde*. Retrieved April 24, 2019 (https://www.lemonde.fr/idees/article/2018/06/12/la-psychiatrie-publique-est-devenue-un-enfer_5313233_3232.html).

[74] This is detailed in a report that notes that "to talk about the impoverishment of psychiatry is not exact." Lopez and Turan, *Organisation et fonctionnement du dispositif de soins psychiatriques*: 23.

Figure 0.10: Protests Against Budgets Cuts in a Parisian Hospital

Translation: "Hospital on its last breath"; "Nurse"
Source: The Author (2018)

resources," the psychiatrist in charge of one *secteur* noted, "Before we were fighting to have a little money [*sous*] to create new projects. Now, we're fighting just not to lose them. I don't know what we'll be fighting for next" (Interview, 6/28/16). "In the face of this indifference, we're dying," a group of hunger-striking nurses in Rovray declared (see Figure 0.10).[75]

That "indifference" was, above all, on the part of politicians and the Ministry of Health. Although France's adult psychiatric system has been the object of nearly two-dozen reports since the 1990s, those reports themselves typically repeat previous recommendations and note the "lack of national leadership" that limited their predecessors' impact.[76] The one member of the National Assembly known for his interest in psychiatry noted, "Given that the mentally ill are not well considered in society, when you take their funding, that isn't going to make anyone cry" (Interview, 6/22/16). As was frequently the case, in French discourse the stigmatization of patients and practitioners, and the poor treatment of psychiatric hospitals and the people who resided in them, were intermixed. At the same time, those in the ministry countered that they were not bringing about psychiatry's decline, but fixing a perpetual "French delay" psychiatrists themselves have created: a delay in the diagnosis of autism, a delay in the adoption of new therapies, a delay in investing in community-based treatment, and a delay in the embrace of new concepts like "recovery" or "empowerment" (Fieldnotes, 5/12/16). The 2018 Strategic Plan for mental health is a wish-list of programs—from smart-phone apps to Telemedicine to Housing First—developed in other countries and brought to France with little new funding to close the gap.[77]

For the U.S., many of the themes were the same, but their temporality and valance were different. For example, while the French talked about cuts to a system that, at least previously, was comparatively well-funded, U.S. informants saw only chronic neglect since the states divested from the state hospitals in the '60s and the federal government abandoned community mental health in

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[75] Esclauze, Aurore. June 6, 2018. "A l'hôpital du Rouvray, 'La situation devient critique' pour les grévistes de la faim." *Le Monde*. Retrieved April 24, 2019 (https://www.lemonde.fr/sante/article/2018/06/06/a-l-hopital-psychiatrique-du-rouvray-greve-de-la-faim-pour-des-moyens_5310386_1651302.html).

[76] Barres, Martine. 2016. *Évaluation du plan psychiatrie et santé mentale 2011-2015*. Paris, France: Haut Conseil de la santé publique. See, also, Basset (2013).

[77] Ministère des Solidarités et de la Santé. 2018. *Feuille de Route: Santé Mentale et Psychiatrie*. Paris, France.

the '80s. While conflicts between politicians and professionals in France consisted of arguments about what to do with the most seriously mentally ill, critics in the U.S. felt this population had been forgotten entirely:

> Historically, SAMHSA [the Substance Abuse and Mental Health Services Administration] and CMHS [Center for Medicare and Medicaid Services] have been part of the problem, not the solution. They spent mental-health resources on improving mental wellness among the masses, rather than on lowering rates of homelessness, arrest, incarceration, and needless hospitalization of the seriously mentally ill.[78]

Unsurprisingly, my U.S. interlocutors discussed a "desperate struggle"[79] to access care, which necessarily superseded the concerns over treatment quality primary for the French.

Unlike in France, in the U.S. no one save a few officials in New York (which still had the fifth highest density of psychiatric beds in the country[80]) seemed worried about people lingering in hospitals. Rather, the concern was with *trans*-institutionalization: the movement of people with severe mental disorders into prisons and jails, nursing and boarding homes, and onto the street (see Figure 2.1). In a sense, the French were trying to break the mentally disordered out from their all-encompassing status of "patient"; in the U.S., professionals had largely abandoned getting the mentally disordered out of these social and judicial institutions (or non-institutions, in the case of homelessness) and shifted to trying to deliver some minimally adequate treatment and recover a bit of "patient-hood" within them.

That each country's mental health system would seem to be in "crisis" is unsurprising. As Saxena et al. (2007:878, 885) find in their sweeping survey of worldwide mental health financing, there is a "widespread, systematic, and long-term neglect of resources for mental health care." They conclude that "mental health policy is unfairly disadvantaged by the endemic stigma attached to mental illness." But crisis narratives, as research on the "crisis" of crime in '70s and '80s shows, are less about objective description and more an exhortation to action (Garland 2001; Simon 2007). One could easily tell the story of mental health care by focusing "less on how it produces order and more as it never ceases to fail to do so" (Jaeger 1981:12), which each failure providing justification and motivation for new pleas for funding and waves of reform.

Irrespective of whether each system is really in "crisis," I do argue that there are three overarching tensions in both, each of which is over the social statute of the severely mentally disordered. In Chapter 1, I examine how, in each country's health system, a historically specific response to a small, bounded group of "mentally ill" is under strain from pressures to dissolve mental illness into a broader continuum of "mental health," to be addressed in a manner consistent with the increasingly technical and rationalized approach to physical medical conditions. In Chapters 2 and 3, I engage with a second tension. Each country's social or disability support system operates under an imperative to render the severely mentally disordered autonomous, which co-exists uneasily with the chronic impairments created by severe mental illnesses. In Chapter 4, I look at the collision between psychiatry and the judicial sphere. Here, the long-standing role of the mental health system in ensuring social control runs up against the expectation that the mentally ill are rights-bearing citizens.

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[78] Jaffe, D. J. 2018. "America's Mental-Health Policy Quietly Improves." *National Review*. Retrieved March 20, 2019 (https://www.nationalreview.com/2018/12/american-mental-health-policy-quietly-improves/).

[79] Wiener, Jocelyn. 2019. "For Families across California, a Desperate Struggle to Get Mental Health Care." *CALmatters*. Retrieved May 2, 2019 (https://calmatters.org/articles/californians-struggle-to-get-mental-health-care/).

[80] Lutterman et al., *Trend in Psychiatric Inpatient Capacity.*

These common tensions—health versus illness, autonomy versus chronicity, rights versus control—likely appear in the mental health systems of most other developed countries (see Novella 2010). But, in each, "the range of acceptable solutions is embedded within the different institutional arrangements and historical trajectories" (Kikuzawa, Olafsdottir, and Pescosolido 2008:386) peculiar to that country. In the previous section of the introduction, I outlined the institutional organization of each country's mental health system. In this, I overview how each country has approached these tensions and introduce the key theoretical contributions of this dissertation: "national repertoires of classification," "state kinds," and "serviceable objects."

Tension 1: From Mental Illness to Mental Health

Chapter 1 of this dissertation, "Ration or Rationalize: Allocating Psychiatric Care in France and the United States," examines how each country came to differentially determine the responsibilities of the public mental health system with respect to both individual "mental illness" and population-level "mental health." The embrace of the latter creates a corollary tension between the delivery of care for a widening range of maladies and the concomitant control of costs. As such the chapter examines the elaboration of regulations for psychiatric care and their implementation, followed by an ethnography of level-of-care decisions in a public clinic in each country. I engage with the literature on rationalization and economization in medical services and use this case as an opportunity to move beyond an examination of cross-national differences in the rates at which certain classifications are used and applied to the very *kinds* of categories and styles of classification that predominate in each national context.

My ethnography of a public clinic in France, presented in Chapter 1, centers on how professionals assign care to new patients in the face of the inexorable rise in the caseloads of the public *secteur*—nearly doubling from 1.8% of the adult population in 1981 to 3.5% in 2014 (see Figure 0.11). For both professionals and French commentators, this increase in demand for psychiatric services reflects, as Ehrenberg (2010:17) argues, the way that mental health "has become…the obligatory form of expression not only of wellness or sickness, but also conflicts, tensions, and dilemmas of social life," part of a broader "medicalization of public problems" (Bergeron 2010:82; see, also, Lloyd 2008). At the same time, these professionals had to contend with a push to rationalize and economize French psychiatric care through evidence-based medicine, impact evaluations, harmonization of practices, and budgetary strictures.

I show that public psychiatrists were largely successful in pushing back against "*santé-mentalism*" (a play on "mental health" that works out to something like "mental health sentimentalism"). They drew on a narrative of a need to concentrate resources on caring for "real *malades*." This idea was embodied in the 2012 plan for mental health and psychiatry which announced a goal of "fighting against the excessive medicalization of malaise [*mal-être*]" because "this consumption of resources from the psychiatric apparatus [*dispositifs psychiatriques*] can harm the access for persons with proven mental troubles."[81] However, as I show, in resisting "rationalization," French clinicians were left with little choice other than to simply ration: that is, make binary decisions about who got "in" and who was left "out" of a public system that had little capacity to calibrate or withdraw care.

Chapter 1's ethnography of a public clinic in California examines decision-making by professionals working in an environment where "mental health" has overshadowed "mental illness" in policy discourse and techniques of economic and managerial "rationalization" are deeply embedded in the system. As soon as American psychiatry moved out of the asylum, it also started

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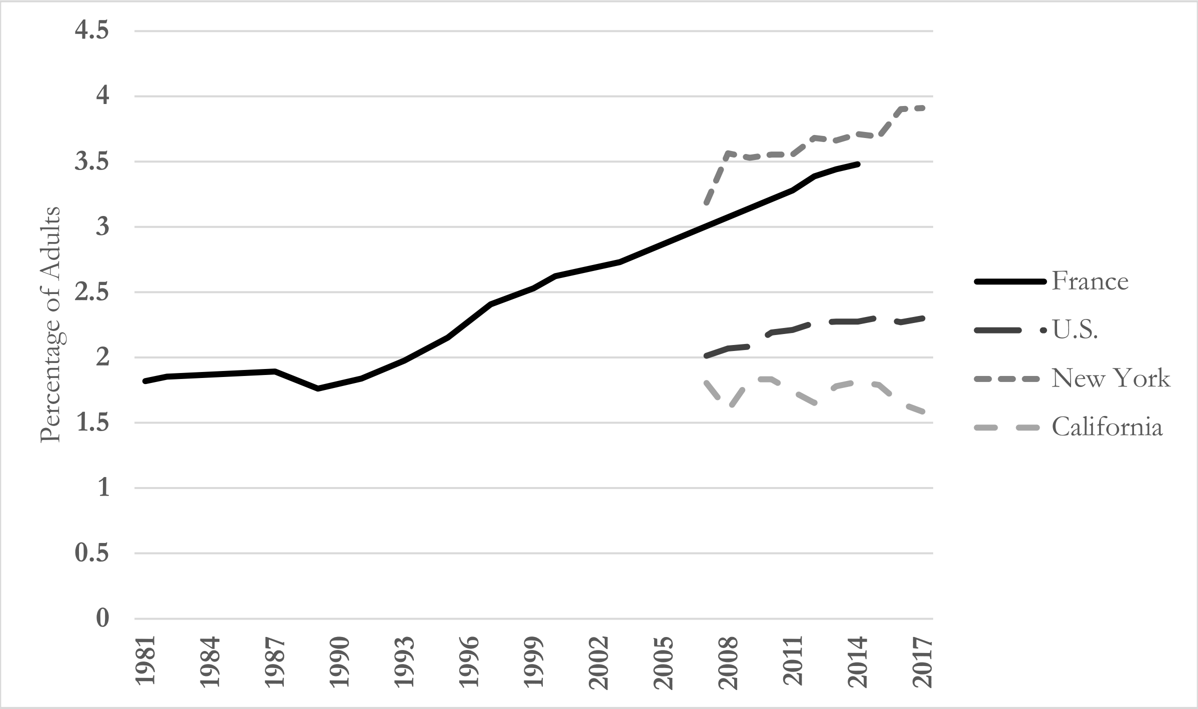
[81] Direction générale de la santé. 2012. *Plan Psychiatrie et Santé Mentale, 2011-2015*. Paris, France: 28.

Figure 0.11: Expansion of Adults with Active File in Public Sector, 1981-2014



Source: Lopez and Turan, *Organisation et fonctionnement du dispositif de soins psychiatriques*; SAMSHA Uniform Reporting System.

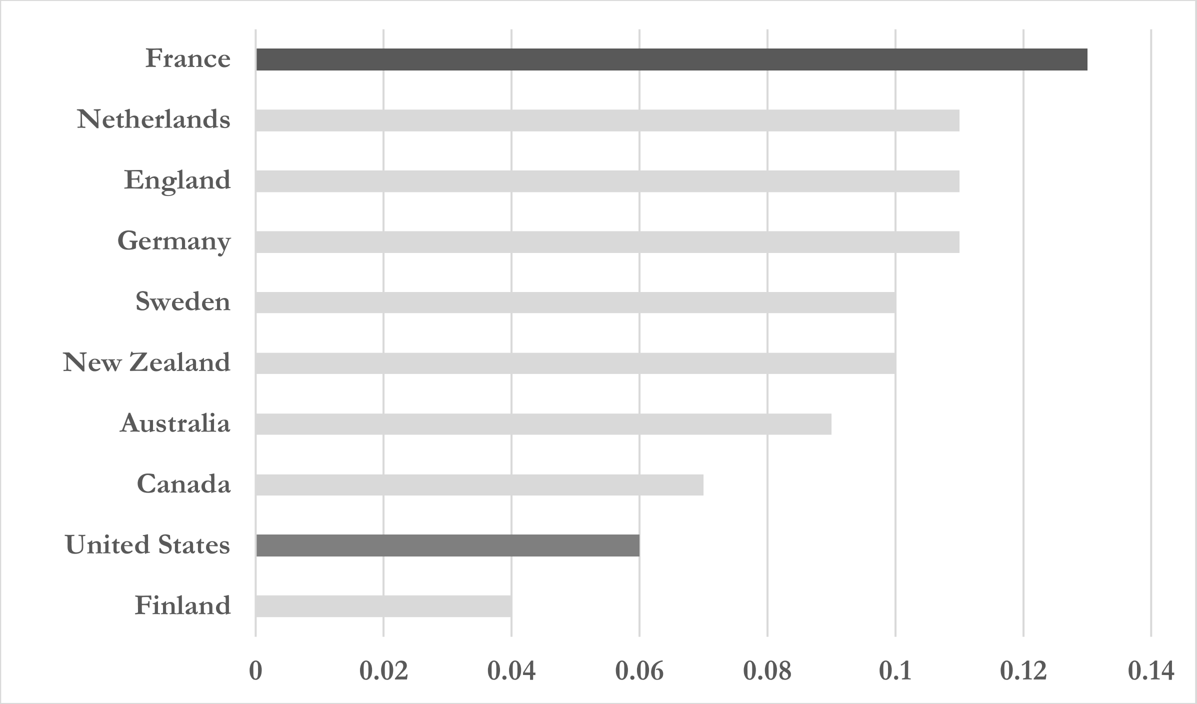
pushing beyond the boundaries of "mental illness" by arguing that we all exist on a continuum of mental health. William Menninger told Congress in 1956, in response to epidemiological studies showing that one-in-four Americans had a mental illness, that:

> Even the most startling of these figures…refer only to extreme cases of mental disorder. [They] overlook the common, everyday emotional disturbances which can be as upsetting and incapacitating as many of the physical illnesses. When we take these into account, the toll of mental ill health must be reckoned as one in one, for there isn't a person who does not experience frequently a mental or emotional disturbance severe enough to disrupt his functioning as a well-adjusted, happy and efficiently performing individual (qtd. in Staub 2011:37).

The National Comorbidity Survey Replication, a gold-standard study for American psychiatric epidemiology, didn't quite hit one-in-one, but found that, as of 2003, over 50% of Americans would meet criteria for a DSM disorder in their lifetime. Treatment use, though, was "disturbingly low" (Kessler et al. 2008:201).

The decision-making practices I examine ethnographically take place against a backdrop of public health campaigns, like New York's "Thrive" initiative, described in detail in Chapter 1, intended to close these treatment gaps. As I observed, public authorities, police, and the community were sending the police more and more cases of people who were "severe" but only ambiguously "mental": the chronically homeless, drug addicts, and people whose behavior stemmed more from personality problems than psychosis. Paradoxically, clinicians had to respond to the increasing number of people pushed into care while also dealing with intense cost pressures. Indeed, the expanding number of people receiving treatment is belied by the fact that mental health accounts for a smaller proportion of U.S. health spending than in other countries, and constitutes a declining

Figure 0.12: Mental Health as a Proportion of Health Spending (2011)



Source: WHO Mental Health Atlas. These data are based on country self-reports in response to a WHO survey; they almost certainly vary in what they contain, although I think the overall picture of France as at the 'high' end of spending and the U.S. at the 'low' is accurate.

share (Figure 1.1, 0.12).[82] This happened not in spite of, but precisely *because,* public payers (namely, Medicaid) has assumed a steadily greater share of mental health spending (Figure 0.13) and, in so doing, subjected it to managerial tools like prior authorizations for hospitalizations, financial incentives for faster discharges, and protocols for stepping patients rapidly to lower and cheaper levels of care (Mark et al. 2007:1044).

The comparative approach of Chapter 1 helps me identify factors that facilitated rationalization in the U.S. and not France. In the former, I show the rise of *institutional medicalization*, or the incorporation of mental health care into the health system (which psychiatrists resisted in France). Surprisingly, though, I show how this has happened alongside the *cognitive* and *normative de-medicalization* of care. For many of the most severe cases in the public clinic, the team had re-defined their normative goals not as addressing symptomology and severity (the distinguishing problems posed by real *malades* in France), but on controlling behaviors and reducing service use. Both their interventions and the cognitive categories through which they reason are often non-medical interventions. Transforming the aims and techniques of care in this way made them easier to monitor, quantify, and pursue mechanically—all hallmarks of rationalization.

In both cases, my findings have implications for medical sociology's emphasis on the role of diagnosis in decision-making. Scholars have emphasized the "pervasive influence" (Halpin 2016:157) of the Diagnostic and Statistics Manual in contemporary mental health care (Armstrong 1998; Brown 1995; Conrad 2007). Diagnoses organize clinical trials, are necessary for insurance, and

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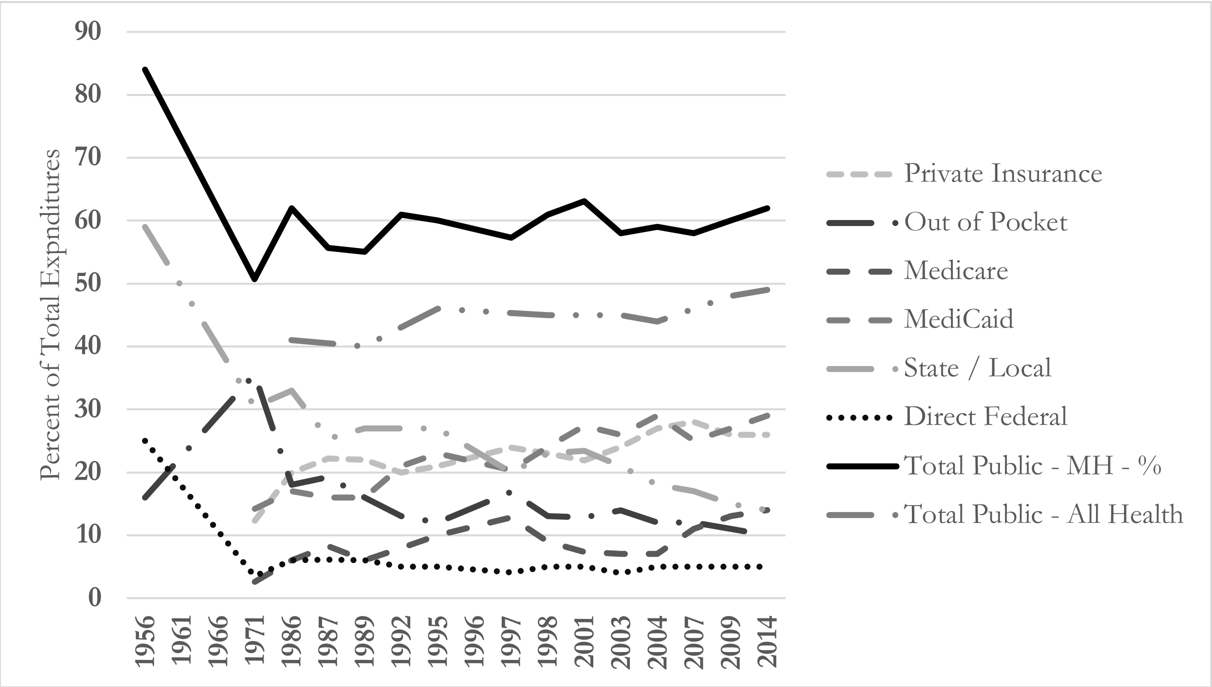
[82] The obvious objection is that the U.S. spends more overall on health, so a smaller proportion masks high overall spending. High spending in the U.S. is largely driven by high prices, not high volume, however.

Figure 0.13: U.S. Mental Health Expenditures, by Payer (1956-2014)



Sources: Mark et al. (2016); Glied and Frank (2006); SAMHSA, *Projections of National Expenditures.*

determine access to benefits. Globally, the DSM is "the psychiatric equivalent of the World Trade Organization, promoting the principles of American universalism as objective standards that are beyond reproach" (Carpenter 2000:615).

Across my field sites, however, I find that diagnosis provides limited leverage to understanding institutional decision-making.[83] In France, a vague label of "psychosis" offers minimal analytical leverage to understand who qualifies for disability income, should be hospitalized involuntarily, or receives intensive outpatient care. In the U.S., antipathy to the DSM was less overt: whether testifying in court on involuntary treatment or admitting someone to treatment, a diagnosis was almost the first thing mentioned. But practitioners quickly moved on to other questions: how impaired is the person? Were they dangerous? What is their social situation? In the moments where I heard about a patient's long history in the mental health system, I was frequently struck by how much a person's mix of diagnoses seemed to change with each institution with which they had contact—and how little professionals seemed to care about this fact. As I argue in the second section, the question of *diagnosis of disease* is frequently secondary to the *classification of people* and the separation and overlap of state recognized populations—criminals, addicts, homeless, dependent poor, etc.

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[83] I am thus indebted to literatures that have critiqued sociology's (over-) emphasis on diagnosis as an explanatory factor, by emphasizing how psychiatrists can work around requirements that they use DSM categories (Rhodes 1991; Whooley 2010), that professionals use different categories when working with clients in practice (Biklen 1988; Dobransky 2009), and that the mere affixing of a diagnostic category does not necessarily drive a person's institutional trajectory or treatment (Bosk 2013; Showalter 2019).

Table 0.4: Classificatory Repertoires in France and the United States

	France	***United States***
Dominant Type of Classification	Nominal; oriented towards membership in a single, overarching category.	Ordinal; oriented towards temporary states, located on multiple continua.
Mode of Classification	Emphasis on professional discretion; suspicion of external tools and formal criteria.	Curtailing of professional discretion through mobilization of external scales and elaborated criteria.
Object of Classification	Subjective states and symptoms.	Objective behaviors and functioning.
Central Tension	Commitment to universalism versus rationing based on groups.	Commitment to rational decision-making violates individualized treatment and deservingness.

Chapter 1 – Theoretical Contribution: Diagnosis and National Repertoires of Classification

Chapter 1 starts with the observation that resources flow from classification (Bourdieu 1984; Goldberg 2005) and asks what categories are used in each country and how they are applied. When I zoom out from the specific and sometimes different categories judges, social workers, or psychiatrists are using in each country, I see more basic patterns in *how* classification takes place (see Table 0.4). Scholars have thought about these patterns in terms of the same concept I evoked in talking about policymaking: "repertoires," or a tool box of ways of organizing action, defining objectives, and evaluating outcomes that are culturally-salient and from which actors can draw in moments of uncertainty.[84] Cultural sociologists have argued that these toolboxes exist at a national level: different countries provide distinctive "cognitive categories" (Christin 2018:1385), "cultural scripts" (Jepperson 1993:11), or "publicly available categorization systems" (Lamont 1995:351) to use to make sense of the world and act on that interpretation. If the way that actors respond to new information or unexpected events are "eminently contingent—on local politics, time period, or social context," they are "contingent in ways that are socially patterned" (Fourcade 2011:724) at a societal level.

The first element of the classificatory repertoire in each country is what kind of categories are used. In France, state agents tended to use "nominal" categories, which are "oriented to essence" and focused on putting things into discrete types (Fourcade 2016:176). When the French state first asked for quantitative information about sub-national departments in the 19th century, they received back detailed qualitative monographs that sought to characterize the area as a whole (Porter 1996:35–36). I think it is not coincidence that the French classification of wine, too, is focused on the combination of history, practices, and land that constitute a *terroir* that produces distinct and often incomparable wines (Fourcade 2012; Zhao 2005). In my research, my informants often talked about psychiatric pathologies as distinctive insofar as they impacted the "whole person" (Figure 0.5) (see Jodelet 1991:155). They wanted to know, in particular, whether those persons were "real *malades mentaux*." These was a qualitatively distinct type from people suffering from only "psychic troubles" or "psychic suffering" or people with addictions, personality disorders, or disruptive behaviors that

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[84] The concept of national "repertoires" has been deployed to understand social policy (Palier 2005), protest tactics (Tilly 2008), and economic valuation (Lamont and Moody 2000; Moreira 2011).

were "not psychiatric" at all. I saw these typologies used both on the ground level and in planning documents.[85]

Second, as I show in Chapter 1's description of resistance to rationalization, there is a pattern in *how* these categories are supposed to be applied and by whom. French psychiatrists have long evinced a hostility to the expectation that they use diagnostic tools or symptom scales in decision making (see Eyraud 2013:167; Henckes 2014:i45). The principle of autonomous professional judgment has been protected even by the institutions responsible for curtailing it, like the High Authority for Health. After reviewing tools for the "evaluation of capacity" in decisions about involuntary treatment, which come from a "primarily Anglo-Saxon literature," that agency noted they are "difficult to transpose to France."[86] In his masterful study of the trajectory of intelligence testing in France, Carson (2007) shows how French psychologists looked at the measure of talent via IQ with distrust. In France, a principle of professional discretion prevails, and each professional group seemed to defer to others when dealing with a certain kind of person (for example, judges deferring to psychiatrists, discussed in Chapter 4).

Third, I find that the *goal* of classification in France has been to understand individual subjectivity in an all-encompassing fashion. This idea often anchored critiques of the DSM:

> I deplore, and I'm not alone, the mobilization of a tool that comes from the U.S.: the DSM. Because the DSM is a tool, maybe it's good for research, but…[it misses that] psychiatry is above all an encounter, where you try to create an intersubjective relationship…With the DSM, there are no more encounters, just the objectification of symptoms. How many times per week? How long? Voila the symptom, voila the prescription…When I'm training psychiatrists, I insist a lot on understanding the account of life from the patient (Interview, 4/5/16).[87]

Although they often stood apart from the rest of French medicine, a focus on the overall resilience and well-being of the patient, rather than their specific pathology or symptomology, has been documented among French doctors elsewhere (Nye 1984; Payer 1988).

Finally, as I reveal in the first paper, each classificatory necessarily runs into situations where it seems incomplete, contradictory, or morally problematic. In France, there was an evident tension between sorting people based on typologies and the egalitarian expectations of a universalistic health system. One nurse admitted:

> Normally, the *secteur* is a public service. Except that, effectively, we have criteria anyway. We might refer them out if they have some means…It's not very 'public service' but that's the way it is. If it's an addiction, we're going to send it out. That's not our specialty (Interview, 3/20/16).

As I show, this was a tension throughout the welfare state. For example, disability advocacy associations sought to sort physical, sensorial, intellectual, or psychiatric disabilities into separate

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[85] This schema was reproduced with remarkably frequency in official documents, even if the terms varied somewhat. For example, the 2005 plan differentiates between "positive mental health," "reactional psychological distress that correspond to trying situations and existential difficulties" and "psychiatric troubles that refer to diagnostic classifications." DGS, *Plan Psychiatrie et Santé Mentale*: 4.

[86] Haute Autorité de Santé. 2005. *Modalités de prise de décision concernant l'indication en urgence d'une hospitalisation sans consentement d'une personne présentant des troubles mentaux*. Paris, France: Service des recommandations professionnelles: 61.

[87] This opposition to focusing psychiatric practice of diagnosis was also explicitly articulated in terms of opposition to the asylum psychiatry inaugurated by Pinel (Henckes 2014:i47; Murard and Fourquet 1975:469; Roelandt 2011:186; Roudinesco 1990:132). This same resistance is identified in another psychoanalytic holdout, Argentina, by Lakoff (2006:60).

services, even as the state, in the name of administrative rationalization, sought to simplify and group together responses to various forms of disadvantage and exclusion (Jaeger 2012).

I identify a distinctive repertoire of classification, extending from system structures to the cognitive heuristics professionals deploy, in the U.S. There, professionals and policymakers largely thought in terms of continua, not nominal categories. One psychiatrist explained:

> I'm not worried at all that severe mental illness is being left out. The issue of severity, I like to say, is more a 'state' than a 'trait' from a recovery perspective. Folks can be in deep trouble for a while, and then they may not be at the same level, and that is going to vary over time (Interview, 1/5/17) (see Rose and Abi-Rached 2013:46).

The French terminology of "*malade mental*" implies that someone's mental disease defines them, whereas the dominant de-stigmatizing discourse is to claim the opposite (see Figure 1.5). This was, administratively, true, insofar as their level of pathology was only one criterion for decision-making, alongside violence risk, addiction, precarity, or disruptiveness.

Second, and closely related, the U.S. system presumes to a much greater degree that expert judgment should be circumscribed with the use of standardized metrics and scales—an observation that has been made of sites as diverse as newsrooms, economics departments, and school-based intelligence tests (Carson 2007; Christin 2018; Hirschman, Berrey, and Rose-Greenland 2016; Porter 1996). One psychiatrist griped:

> We are always seeing more and more protocols in diagnosis, assessment, and record keeping. That's the transition to electronic medical records, which are built around an infinite number of drop-down menus and boxes to check, ostensibly for the sake of completeness, reporting, and rendering data useful for quality assurance and research…This protocolization is really rendering psychiatrists merely a cog in a bureaucratic wheel that is there to check off answers to questions rather than applying independent judgment (Interview, 12/14/16)

Vent though they might, in my ethnographic observations, clinicians pushed one another to check their discretion through the use of decision-making tools and carefully enumerated criteria. They did it not just to please regulators but because it served a deeply-felt aim of insuring equitable treatment.

Third, rationalization in the United States has depended on a shift from subjective to objective criteria, which has facilitated a partial *de*-medicalization of both the goals and modalities of mental health care. In my courtroom observations, for example, judges admonished psychiatrists to "just tell me what you've seen" and to ground predictions of danger on observed behaviors. The shift from "mental" to "behavioral" health[88] is telling. I asked a "Behavioral Health" clinic director:

> *Interviewer:* I think in France they would say, 'that's so superficial and American, you don't think about the inner life of the person.'
>
> *Clinic Director:* No shit. If you're still into psychoanalysis, you're in the wrong field, go into private practice…Just sitting and doing inter-psychic exploration is not what the taxpayers pays us to do…Even if the person's main issue is trauma, you encapsulate, you don't uncover. Don't delve into the past. Stay in the here and now—what do you need to do right now to contain your emotions and behaviors? (Interview, 4/2/19).

As Chapter 1 argues, "rationalization" has advanced much further in the U.S. than in France in part because the meaning of mental/behavioral health treatment has been defined in a way that makes it amenable to evaluation, standardization, and economization.

Fourth, within this repertoire, the chief tension is not between the particular category and the universal citizen, but the particular category and the individual. Lipsky (2010:71) describes the

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[88] The most emblematic example of which is the Federal Government's relabeling of its data-book "Mental Health United States" to "Behavioral Health United States" in 2012 (see Backlar 1996; Hudson 2018).

"myth of altruism" in American public services, that they "treat the whole person…respect and encourage client autonomy, and…respond to the individual rather than to alleged patterns of group behavior." Clinicians' struggled to reconcile their sense of individual deservingness—central to the American welfare state (Katz 1996; Skocpol 1992)—and a mandate to focus resources strategically on the highest service-using and most disruptive clients.

The first part of this dissertation can thus be read as an engagement with Foucault's (1994:xviii) classic claim that modern medicine emerged with a shift in the logic of clinical classification from examining "what is the matter with you?" to "where does it hurt?" Neither question accurately captures the logic through which mental health care is allocated in contemporary France and the United States. In the latter, the answer to "what are you doing?" is determinative; in the former, "what kind of person are you?" These questions reveal, I argue, enduring and nationally-specific patterns in classification that undergird the diagnoses that have attracted the lion's share of sociological interest.

Tension 2: Mandated Autonomy, Real Chronicity

Early psychiatrists claimed that their treatment was extraordinarily efficacious. Pinel assured the ministry that two-thirds of the mad could be cured, were they to be put in the right institution (Gauchet and Swain 1980:75). American Asylum Superintendents were even more sanguine, arguing for more funding from state legislatures by presenting a 90% recovery rate (McGovern 1985:3). Today, though, most clinicians concur with the French "Center of Excellence" for the treatment of schizophrenia that "the therapeutic effects…of psycho-pharmaceuticals…reduce psychiatric symptoms" but do little to dull "associated troubles" with cognition, social interaction, and functioning that prevent many people with schizophrenia from functioning independently.[89] As the head of America's National Institute of Mental Health lamented, "A century ago we had large public institutions for serious mental illness, tuberculosis and leprosy. Of these three, today only mental illness, especially schizophrenia, remains unchanged in prevalence and disability" (Insel 2010:187). Despite this pessimism, international bodies and advocates increasingly insist on the entitlement of even the most chronically mentally ill to "participate fully in human society" (Dudley, Silove, Gale, et al. 2012:vii). How do France and the United States manage these competing imperatives of promoting autonomy and addressing chronicity?

The second part of this dissertation consists of two chapters: "Bureaucratically Split Personalities: Ordering the Disordered in the French State" (Chapter 2) and "The Mental Illness Merry-Go-Round: Reconstructing California's Continuum of Constraint" (Chapter 3). The concept of "chronicity," central in both chapters, reorients attention away from curative medicine towards social care and support (Bister 2018). In both cases, the response to the tension between rights and impairment hinges on the relationship between "mental illness" and "disability." While in France "disability" has emerged as a lever to promote autonomy amidst chronicity, in California "grave disability" has become a wedge to acknowledge the chronicity of autonomous selves. In this section, I overview these tensions in each country before elaborating my theoretical contribution, organized around the literature on professions and street-level bureaucracy and my conceptualization of "state kinds."

As I show in Chapter 2, at the advent of *sectorisation,* people with severe mental disorders in France were treated as acutely ill in public discourse and chronically ill in practice. 1968 legislation that reclassified psychiatric hospitals as "acute care institutions" was crucial for raising the status of

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[89] Hardy-Baylé, *Données de preuves,* 58.

psychiatry in the health system,[90] but in a moment where the average length of hospital stay was 234 days, it was more aspirational than descriptive. The debate sharpened in 1975, however, when the French government established the country's "disability" (or "medical-social") system by unifying a range of protected workshops, rehabilitation centers, and residential schools that had been created by private associations for disabled workers, soldiers, and children (Bauduret and Jaeger 2005; Chauvière 2018; Romien 2005). Psycho-analytically oriented psychiatrists, however, fought successfully against qualifying the severely mentally ill as "handicapped," arguing that these structures were "a new ghetto" (Ayme 2002:181) to replace the old ones, asylums, they were just starting to reform.[91] Instead, *secteurs* were to provide both short-term "cure" and long-term "care," which were separated in other countries, like Germany (Hollingsworth 1992). The arrangement spoke to a broader skepticism in France of "autonomy" as a synonym for the abandonment of protection and solidarity (Ehrenberg 2010).

Over time, France's disability sector has shifted away from providing charity towards, as one minister put it, "permitting handicapped persons to exercise fully their citizenship in the context of a free choice of their mode of living," and exercise that "can only be made under the condition of the maximum restoration of autonomy to the person."[92] This new approach drew on strengthening international and European norms around disability (Waldschmidt 2009), the vigorous advocacy of associations for people with physical and intellectual disabilities,[93] and, arguably, a neo-liberal turn by which the state used a discourse of individual responsibility and civil-society delegation to limit its obligations (see Bouquet and Jaeger 2017; Dubois 2003; Hocquet 2012). In this context, the association of parents of the mentally ill, UNAFAM, succeeded in incorporating into a 2005 reform recognition of "psychic handicap," or a "substantial, durable, or definitive alteration of…psychic functions"[94] caused by mental illness that create a "restriction of activity or of life in society."[95]

Chapter 2 analyzes the practical difficulties in "making" a new population of autonomous psychically-disabled/chronically mentally-ill persons, drawing on an ethnography of the Parisian *Maison départementale des personnes handicapées* (Department Home for Disabled Persons, or MDPH). This institution is charged with taking a person's "life project" and transforming it into a "personalized plan of compensation" that could include employment supports, housing, aid in daily life, or income.[96] I elaborate the concept of "bureaucratically split personalities" to explain the difficulties French bureaucrats faced in commensurating and merging two previously distinct populations and bringing the mentally ill into disability services. In many cases, even nominally independent disability evaluators they fell back on the typologies from the health system of "real *malades*" versus people with "psychic troubles" or non-psychiatric conditions. Ultimately, I argue that the pursuit of "autonomy" in France will likely advance primarily within the health system itself, and through the continuing bureaucratic treatment of the severely mentally disordered as, above all, *malades* (see, also, Moreau and Laval 2015).

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[90] République Française. 1968. *Loi n° 68-690 du 31 juillet 1968 portant diverses dispositions d'ordre économique et financier.*

[91] My narrative here is deeply indebted to the work of Henckes (2011a).

[92] Aubry, Martine. 1999. *Plan d'action pour le développement de l'autonomie des personnes handicapées dans leur milieu de vie ordinaire.* Paris, France: Secrétaire d'État à la santé et aux handicapés: 1-2.

[93] Accounts of the lobbying for the 2005 law include Cunin (2008), Barral (2007), Winance (2007), and Power et al. (2014).

[94] République Française. 2005. *Loi n°2005-102 pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées.* Retrieved October 4, 2017 (https://www.legifrance.gouv.fr/).

[95] UNAFAM. 2001. *Le livre blanc des partenaires de Santé Mentale.* Paris, France: 12.

[96] My analysis builds on previous French research that looks at the processing of demands in the MDPH more broadly (Baudot 2013; Baudot and Revillard 2014; Bertrand, Caradec, and Eideliman 2014; Bureau et al. 2013).

In contrast to France, de-institutionalization in the U.S. embarked with the expectation that community care would overcome chronicity entirely. When Kennedy announced the national policy of de-institutionalization, he articulated a therapeutic optimism that almost rivaled the exaggerated cure rates of early proponents of moral treatment:

> Tranquilizers and new therapeutic methods now permit mental illness to be treated successfully in a very high proportion of cases within relatively short periods of time—weeks or months, rather than years…I am convinced that, if we apply our medical knowledge and social insights fully, all but a small portion of the mentally ill can eventually achieve a wholesome and constructive social adjustment.[97]

In the juxtaposition between the aspirations of Kennedy and the reality of state hospitals, it's not surprising that the former won more adherents: indeed, he was drawing on deeply engrained notions of the American self as always capable of progress and improvement, invariably towards an end of greater independence and autonomy (Bellah et al. 1985; Weber 2001 [1905]).

Even if Kennedy was in retrospect a Pollyanna, this dissertation documents how the public mental health system as designed presumes that mental illnesses are acute and at least potentially improving. For example, by 2010, the median length of stay in American psychiatric hospital was down to six days (versus nearly thirty in France – see Table 0.5).[98] One community clinician told me, "Hospitalization is for stabilization not treatment. We view them as likely to stay 72 hours maximum. We can send them, but they get reassessed in the ER and often just discharged" (Interview, 1/19/18). The time frame for outpatient care was different, but the overall pressure the same. In Chapter 1, I document how both managed care companies and county (in California) and state (in New York) mental health directors pressure providers to drop patients to lower levels of services and, ideally, out of the public system entirely. In both cases, professional practices track with the idea of "recovery" as the goal of treatment, whereby services "focus on increasing consumers' ability to successfully cope with life's challenges"[99] on their own (see, also, Jacobson and Greenley 2001; Padwa et al. 2016; Pilgrim and McCranie 2013).

Chapter 3 deals with the tension between this system geared towards autonomy and the reality of chronicity as it faces two aggravating trends. First, many Adult Residential Facilities (like nursing facilities or board and care homes), in the face of tightening regulations and rising costs, are closing.[100] Second, policymakers and pundits rediscovered chronicity at the nexus of severe mental illness, drug addiction (particularly, methamphetamine), and homelessness. I follow, in particular, debates over the expansion of "conservatorship," a form of legal guardianship for the mentally ill that allows the state to mandate someone to live in a locked facility and to take medication—not for days, like most hospitalizations, but months or years. The fight over conservatorship hinged on the legal standard of "grave disability": in France, disability became a lever for making chronic patients autonomous; in the U.S., for making the autonomous addicts into chronic patients.

Chapter 3 makes two other points about the shape of the contemporary mental health system. First, it documents the strange incongruities of a system that depends heavily on the legal power of the state, but which also respects the prerogatives of private actors. Judges, under

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[97] Kennedy, *Special Message to the Congress.*

[98] It's important to note that this disparity is greater than that which we would expect from differences in the number of beds alone. Put otherwise, the U.S. occupies its beds with more frequent, shorter stays vis-à-vis France.

[99] President's New Freedom Commission *Achieving the Promise,* 5.

[100] California Mental Health Planning Council. 2017. *Adult Residential Facilities (ARFs): Highlighting the Critical Need for Adult Residential Facilities for Adults with Serious Mental Illness in California.* Sacramento, California.

Table 0.5: Selected Comparative Indicators

	France	**Paris**	**United States**	**New York**	**California**
Median Length of Hospitalization (days)[*]	29.4 (2016)	32 (2014)[◆]	6.7 (2010)	12 (2016)	N/A
Public Mental Health Caseload, % of adults[□]	3.4 (2014)	2.8 (2014)	2.2 (2017)	3.9 (2017)	1.6 (2017)
Rate of Involuntary Hospitalizations per 10,0000 Adults[^]	16.1 (2015)	19.4 (2015)	N/A	32 (2011)	46.5 (2016)

* For U.S., drawn from SAMHSA. *Behavioral Health United States*; for France, Direction de la recherche, des études, de l'évaluation et des statistiques. 2017. *Les dépenses de santé en 2017: Résultats des comptes de la santé*. Paris, France; for Paris, From Reyes, Lazare and Michel Lejoyeux. 2014. *Psychiatrie et santé mentale: Rapport commun des DIM*. Paris, France: Communauté hospitalière de Territoire pour la psychiatrie parisien.

◆ Data are average (not median) stay, but exclude long-stay patients.

□ For U.S., data from SAMSHA Uniform Reporting System; for France, Lopez and Turan, *Organisation et fonctionnement du dispositif de soins psychiatriques*; Hirsch and Strizyk (2016)

^ For California, drawn from Involuntary Detention Reports FY15-16; for New York, estimated from Shea (2012); for France, estimated from Lopez and Turan, *op cit.*; for Paris, Atlas Santé Mentale France.

increasing pressure from communities to "do something" about disruptive homelessness, can mandate that counties "place" a conservatees in a locked facility. But counties cannot force any given facility to take such a client, and, with a surfeit of demands for residential facilities, those private actors had many reasons not to. In California, the ability to use legal coercion effectively depended on the vicissitudes of market pressures that were leading locked and unlocked sub-acute facilities to close.

Second, the paper ends with tentative discussions about a dramatic swing back of the pendulum. When I asked my interviewees what they saw as the biggest challenge facing the system, many answered, with very little reflection, "housing" (see Figure 3.9). But while "housing" might initially evoke the supported, independent apartments that have seemed like the ideal destination for the severely mentally ill, more and more interviewees meant something different. Over the period of my research, a surprising number of California counties announced plans to build new locked facilities. If the U.S. and France have historically placed a differential emphasis on autonomy versus long-term care, the gap may be closing. Almost no one spoke favorably of the old state hospitals, but many thought that, at some point, their closure went too far. A New York Times headline after a mass shooting attributed to mental illness was revealing: "Trump wants more asylums—and some psychiatrists agree."[101]

Chapter 2 and 3 – Theoretical Contribution: Professions, Street-Level Bureaucrats, and State Kinds

Both Chapters 2 and 3 raise questions about how responsibility for people with severe mental disorders is divided between wings of the state, about which the sociological literature offers ambiguous predictions. On one hand, the mentally ill are people over who multiple sets of actors can claim a degree of expert knowledge and authority for intervention—the hallmarks of

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[101] Carey, Benedict. August 9, 2018. "Trump Wants More Asylums — and Some Psychiatrists Agree." *The New York Times*. Retrieved April 30, 2019 (https://www.nytimes.com/2018/03/05/health/mental-illness-asylums.html).

"professions" (Abbott 1988; Eyal 2013; Freidson 1973). From this perspective, we would anticipate that the key candidates for jurisdiction over the mentally ill, like psychiatrists, social workers, or judges, would fight to impose their own definitions of mental illness and the primacy of their own interventions in governing them (see Casalino 2004; Kellogg 2014).

Recognition that states are actually fragmented and their action marked by internal conflict (see, e.g., Haney 1996; Loveman 2007; Morgan and Orloff 2017) moves attention to an alternative literature. Professionals working in the public sector may actually act as "street-level bureaucrats": classifying agents that face competing institutional demands, a perpetual lack of resources to achieve them, and significant discretion in decisions about eligibility for services (Lara-Millán 2014; Seim 2017; Vassy 2001). This literature suggests that bureaucrats use classification by-and-large to "burden shift" unwanted cases onto others (Dubois 2003; Prottas 1979). As Lipsky (2010:3) classically argues, it is the aggregate of these decisions that "add up" to welfare policy, often in ways unintended by policymakers.

Despite their somewhat opposing orientations, I see similar lacunae in each literature. As Eyal (2013) argues, the scholarship on professions has under-considered the conditions under which professionals act on the jurisdictions that are formally granted them. The literature on street-level bureaucrats, for its part, has done an excellent job of enumerating the different tactics of managing excess demands—like "rubber stamping" or "creaming"—that are "endemic in organizational life." But, as Lipsky (2010:181) notes, "this says nothing about…the orientation of adaptive attitudes." That is to say, we don't know why state agents toggle between burden-shifting and jurisdiction-claiming in different situations.

In Chapters 2 and 3, I focus on how state agents operate through placing individuals, both in their own minds and in administrative practice, into discrete "human kinds." As Hacking argues, the "making up" of human kinds represents a way of governing people through placing them into groups about which there seem to be "general truths…sufficiently strong that they seem like laws about people, their actions, or their sentiments" (Hacking 1995:352). Human kinds are necessarily normative, offering shared conceptions of what kinds of persons have "intrinsic moral value" and which do not (Hacking 1995:367). As such, our "knowledge" of different human kinds provides "principles through which we can interfere, intervene, help, and improve" (Hacking 1995:360). We can thus think of human kinds as discrete packages of bureaucratic and scientific knowledge, normative evaluations, and interventions that flow from them.

My argument is that the push and pull between professional groups and street-level bureaucrats in each country is organized around distinctive conceptions of who the mentally actually *are*. Although Hacking (1995:359) conceives as human kinds as "begin[ning] in the hands of scientists of various stripes" and usually remaining there "for a while," I use the term "state kinds" to emphasize how these principles become institutionalized in state agencies, providing "cognitive frames" that "give meaning to the collective project" (Dobbin 1994:9) of governing populations. Further extending the logic of classification elaborated in the previous section, I find that in France agents in the health, social, and judicial system have a shared conception of the "mentally ill" as a distinctive and discrete group. Noted one personal working in the national disability agency:

> We are very much a country of 'little boxes.' That is to say, you're black or white, schizophrenic or normal, [mentally] retarded or intelligent. You can't be multiple things at the same time You can't be *malade* and handicapped at the same time (Interview, 4/12/16).

This common knowledge of this human kind was part of why both judges and disability professionals (mostly psychologists and social workers) were reluctant to expand their jurisdiction when the opportunity was opened to them: they did not see the severely mentally disordered as "of a kind" with the populations they knew and felt they could efficaciously process.

In Chapter 3, on the other hand, I examine what happens to people in the U.S. who seem to be bereft of a clear "state kind." The persons considered for conservatorship appear to have characteristics that exclude them from the standard "kinds" of mentally ill, addicts, or homeless. Their exclusion is *not* only based on evaluations of their "deservingness," the key category typically deployed in analyses of the U.S. welfare state (Katz 1996; Steensland 2006), but a more basic confusion about what their problem actually is. They are, to quote Foucault (2008:54), exemplary of how the severely mentally disordered can become the "residue of all residues, the residue of all the disciplines, those [that are] are inassimilable" to all other interventions for governing populations. Chapter 3 thus shows, in microcosm, the ambivalence towards the mentally disordered I have charted throughout American history: at one moment, subject to a host of state interventions based on their simultaneous labeling as dangerous, disability, and diseased, in another, the object of almost none at all.

Tension 3: Controlling Danger, Preserving Rights

Chapter 4 ends this dissertation with the classic question of the social control of the mentally ill. As Foucault (1964) so famously pointed out, states thought the mentally ill needed to be interned long before recognizing they should be treated. A 1791 law in France, for example, punished "those who let ramble the insane and raving mad, or pernicious or ferocious animals."[102] Today, for its starkest critics, psychiatric treatment is "camouflage for attempts to identify and control groups that pose threats of one sort or another to law and order" (Castel et al. 1982:200). In truth, though, while the classic thinkers of Western liberalism, like Locke, Kant, and Mill, "excluded those suffering from mental disorders from persons qualifying for rights" (Dudley, Silove, and Gale 2012:25), today imperatives of social control must contend with increasingly entrenched patients' rights to consent and choice.

My fourth chapter, "Courting Compliance and Consent: Psychiatric Patients as 'Serviceable Objects' in Paris and New York," analyzes how this tension plays out in judicial hearings on involuntary hospitalizations. The reality of the work of lawyers, judges, and psychiatrists in this setting is far from the production of "self-governing subjects" envisioned by psychiatry's boosters and feared by academic critics like Foucault and Nicolas Rose. Rather, I show that professionals are looking to create what Goffman called "serviceable objects"; persons who provide the minimal level of cooperation necessary to keep moving through an under-resourced system. In so doing, I reveal how the French and American states require very different inputs for basic bureaucratic functioning.

The law of 1838 in France created two pathways into the asylum: one based on a need for treatment, as determined by a psychiatrist and supported by a third party (usually a family member), the other, based on behavior deleterious to the public order, as determined by an agent of the state. Left out of this marriage of medical care and administrative control were judges, whose general weakness in France vis-à-vis Anglo-Saxon countries is well-documented (Garapon and Papadopoulos 2003). Over time, though, the law fell into disuse: in 1965, 84% of patients in French psychiatric hospitals were there involuntary; by 1985, it was only 34%, and of new admissions, 9% (see Figure 4.2). But *secteur* psychiatrists at the time rarely spoke of a utopia of "rights" in which involuntary hospitalization would disappear. Rather, a comprehensive system of long-term, consistent care, in which patients would come to trust their doctors through repeated engagement, ensuring their citizenship through provisioning solidarity. The French system at the time was, one

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[102] *Décret du 19 juillet 1791 relatif à l'organisation d'une police municipale et correctionnelle.* Retrieved May 24, 2019 (https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=LEGITEXT000006070181&dateTexte=20071221).

representative of a (non-psychiatric) patients' movement told me, one of "the paternalist doctor who knows what is good for his patients" (Interview, 2/28/16).

After a period where forced placements seemed to go down to an "incompressible remainder,"[103] starting in the 1990s, rates of involuntary hospitalization started to go up. Psychiatrists blamed illicit drugs, budget cuts, increasingly precarious patients, and a security-obsessed society. France is not the only country where an overall decline in hospital beds has led to more of them being used (in absolute terms) involuntarily (Allison, Bastiampillai, and Fuller 2017; Gandré et al. 2017), but for a psychiatric profession that had made voluntary care a metric of its own success, the shift was disturbing.[104] The situation took a much more drastic turn under the mandate of President Nicholas Sarkozy, who used the occasion of a murder by an escaped psychiatric patient to call for psychiatry to "submit the potentially dangerous sick to a special surveillance."[105] Coming on the heels of an attempt to include psychiatry in a law on delinquency (Senon and Jaafari 2008), this "confusion between health and repression"[106] was still raw in many of my interviewees minds.[107]

While Sarkozy and organized psychiatry were fighting over a proposed reform that would give the administration more oversight of medical decision-making and allow psychiatric coercion to extend into the community, a small group of patients were busy litigating over the absence of the judge in the whole process. One legal advocate recalled the lonely fight: "We were doing it against medical advice, against public power, against the majority of psychiatrist unions, against the judges who didn't even want to do it…and against many of the associations of users in mental health who saw us as paranoid [people] to marginalize."[108] These marginals actually won before the Constitutional Council in 2010, which determined that the usual justifications for involuntary care—the need to "protect the health of the mentally ill" and "prevent violations of public order"—had to be balanced with the "protection of the rights" of individual patients by a judge.[109]

Chapter 4 examines judiciarization as it was implemented in Paris. For many French scholars, the intervention of the judge has done little to arrest a gradual "securitarian turn" in psychiatry, that has seen it enthusiastically embrace new hyper-secure hospital units and long-term obligatory outpatient treatment.[110] What I find, though, is a continuing insistence from psychiatrists

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[103] Zambrowski, *Moderniser et diversifier,* 31.

[104] All things are relative. The best attempt to create comparable data across Europe (around 2000) showed that France was in the bottom rung of countries for the proportion of hospitalizations which were involuntary; only Belgium, Portugal, and Denmark were lower (Dressing and Salize 2004). The fact that Austria, Germany, and Finland had rates nearly twenty times higher should raise some eyebrows about data quality.

[105] Sarkozy, Nicolas. December 2, 2008."Déclaration du Président de la République sur la réforme de l'hôpital psychiatrique, notamment la prise en charge des patients à risque." Antony, France.

[106] Noël, David. 2008. "Psychiatrie : Sarkozy confond santé et répression." *Section d'Hénin-Beaumont du Parti Communiste Français*. Retrieved April 27, 2019 (http://www.lheninois.com/article-25551001.html).

[107] It certainly has not helped this feeling die down that successive administrations have continued to suggest things like "mobilizing the psychiatric hospitals against the terrorist menace," as the Interior Minister proposed in 2017 The case, once again, highlights just how unique the powers granted to psychiatry are: the police could not hold persons under the notorious "*fichier S*" watchlist before they did anything; psychiatric, hypothetically, could.. Gourion, David. August 21, 2017. "Terrorisme : 'les psychiatres n'ont pas vocation à collaborer avec le ministère de l'intérieur.'" *Le Monde*. Retrieved April 27, 2019 (https://www.lemonde.fr/idees/article/2017/08/21/les-psychiatres-n-ont-pas-vocation-a-collaborer-avec-le-ministere-de-l-interieur_5174728_3232.html).

[108] Bitton, André. 2018. *Bulletin d'information Trimestriel N°29*. Paris, France: Cercle de Réflexion et de Proposition d'Actions sur la psychiatrie: 3.

[109] Conseil constitutionnel. 2010. *Décision n° 2010-71 QPC*. Paris, France.

[110] As with many points in this dissertation, I find the observations made in the French literature (Collectif Contrast 2016; Marques, Eyraud, and Velpry 2015; Marques, Saetta, and Tartour 2016; Protais 2014; Velpry and Eyraud 2014) to

that "psychiatrists are above all doctors, the prevention of criminality and the maintenance of order not being among their competencies" (Leboyer and Llorca 2018:231; see, also, Lafaye 2016). Judges largely deferred to psychiatrists on this point, defining the people before them as patients whose "premier right," the judges' training manual put it, was "the right to <u>care</u>" [emphasis theirs].[111] Another government report offered a similar prioritization: "current legislation recognizes the involuntarily hospitalized *malade mental* the same rights as any other patient. The restrictions placed on those individual liberties are limited to those necessitated by the state of his health and the putting in place of treatment."[112] The result, a French psychiatrist observed while writing for an American journal, was that, while the U.S. embraced "dangerousness criteria, extensive procedural protections, and judicial review," nations like France "have struck a balance different from the U.S.…between the interests of people with severe mental illness in receiving treatment and their liberty and autonomy interests" (Gourevitch et al. 2013:609). That balance was not so different in 2011 as in 1838.

In the U.S., I document a shift from law *against* medicine to law as a lever to *get* medicine that is otherwise inaccessible. Despite a more powerful judiciary and a greater hostility to government intrusions into private life, the state hospital system as it consolidated in the 19th century was not particularly solicitous of the rights of patients (Appelbaum and Kemp 1982). Through the 1970s, however, American courts imposed more and more due-process protections on involuntary commitments and, in most states, made some form of "dangerousness" a necessary criterion (Appelbaum 1994). The change shifted the basis of hospitalization from the states *parens patriae* to its police powers; control, not care, was the only through that could outweigh patients' negative rights.[113] Surprisingly, the American Psychiatric Association was supportive of these shifts, because they believed, like their French counterparts, that "most persons who need hospitalization for mental illness can and should be informally and voluntarily admitted to the hospitals in the same manner that hospitalization is afforded for any other illness" (qtd. in Appelbaum 1994:29). Some older literature really does show how doctors, lawyers, and judges all worked towards getting acutely ill patients to accept care voluntarily (Holstein 1993; Lewis et al. 1984). In any case, sociologists studying new commitment hearings concluded that an underlying "commonsense and taken-for-granted perspective on mental illness" (Warren 1982:140) led law to largely concur with medicine that the most severely mentally ill belonged in a hospital, whether or not they wanted it.[114]

As beds have dramatically closed in the U.S., though, "voluntary inpatient status" seems like it has "become a thing of the past" (Rose 1998:184). At the hospitals in California and New York where I did my research, psychiatrists estimated that only between five and twenty percent of patients were admitted voluntarily (Interview, 11/28/16, 11/30/16).[115] It might be an exaggeration to say that "to get into the hospital here takes an act of God" (qtd. in Miller and Hanson 2016:64), but it really does increasing take an imminent risk of danger to oneself or others (Werth 2001). This surge in involuntary hospitalizations both as a proportion of hospitalizations and in absolute

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be accurate descriptions of the direction of the general transformation of the French system, but find that, from a comparative perspective, these tendencies are still far less developed than in the U.S.

[111] École Nationale de la Magistrature. 2013. *Soins Psychiatriques sans Consentement*. Paris, France.

[112] Lopez and Turan, *Organisation et fonctionnement du dispositif de soins psychiatriques*: 2.

[113] The use of "grave disability" as a criterion for civil commitment, discussed in Chapter 3, is one work around.

[114] The raft of studies produced in these decades are remarkably consistent showing the limited impacts of judicial review (Bursztajn et al. 1986; Hiday 1977, 1981, 1983; Kumasaka and Gupta 1972; Parry, Turkheimer, and Hundley 1992; Wenger and Fletcher 1969).

[115] There are no national data on the total number of hospitalizations nor the proportion which are involuntary. Lincoln (2006) reports that 78% of admissions at the urban emergency room she studied were involuntary.

numbers (see Figure 4.3) has provoked almost none of the reflection seen in France. A renowned psychiatric professor told me:

> In the '70s, commitment was a hot topic, and that spawned a large number of studies in the '80s aimed at determining what the consequences of that reform had been. Once that wave of reform was spent, there was an extent to which funding for such work diminished. It's not the sort of thing that the NIMH funds these days. Once we figured out what the consequences of the wave of reform was, people moved on. We're on to new questions. No graduate student does a dissertation on the same question that someone else has just done a dissertation on (Interview, 12/14/16).[1]

The last major federal report on America's mental health system did not mention involuntary treatment once.[116] There is no database that tracks involuntary commitments, and only four states provide full data on commitments, despite my research team's Freedom of Information Act requests.[117] But it would be a mistake to pretend that involuntary hospitalizations have gone away: a back of the envelope calculation extrapolating from the limited data available suggests that vastly more Americans are involuntarily hospitalized each year than subjected to legal forms of coercion that have attracted more attention (Figure 0.14).

Chapter 4 uses commitment hearings in New York as a strategic site to analyze the collision of judicial rights and medico-legal control in a mental health system where norms around involuntary treatment, the training and engagement of lawyers for the mentally ill, and the availability of services outside the hospital and beds within it differ substantially from previous studies. It is true that, as in those studies, and as in France, doctors usually win, and patients usually stay in the hospital. But hearings simultaneously unveil lawyer's frustration with the limited power of psychiatrists to help their clients and expose the new ways that the law is being used to force housing and outpatient providers to take difficult patients.

In short, in France, a system that one sought to balance "care" and "control" in France now must, subsequent to a 2011 reform, deal with the intrusion of "rights" (in this case, unlike the positive "right" to autonomy discussed in the previous section, "negative rights" such as freedom from indefinite internment and unwanted treatment). In the U.S., by contrast, an equilibrium of judicially-ensured "rights" and psychiatrically-imposed "control" in place since the 1960s must confront the atrophy and inaccessibility of "care."

Theoretical Contribution: From Disciplined Subjects to Serviceable Objects

What are the ends of psychiatric coercion? Older debates on the asylums asked whether internment was a form of paternalist assistance, direct form of policing social disorder, or response to the dislocations of advancing capitalism (Goodwin 1997; Scull 1977; Sutton 1991). Foucault (1981) argued that, over time, psychiatry pivoted from controlling a handful of individual, dangerous *malade* to managing risk throughout the population. Nicolas Rose (1998:180) pushed this analysis further: "Throughout the country, in thousands of offices, team meetings, ward rounds, case conferences, techniques are being devised to identify levels of risk, signs of risk, indicators of risk, and the like, to measure risk levels, to document risk levels in case notes and care plans." Identifying

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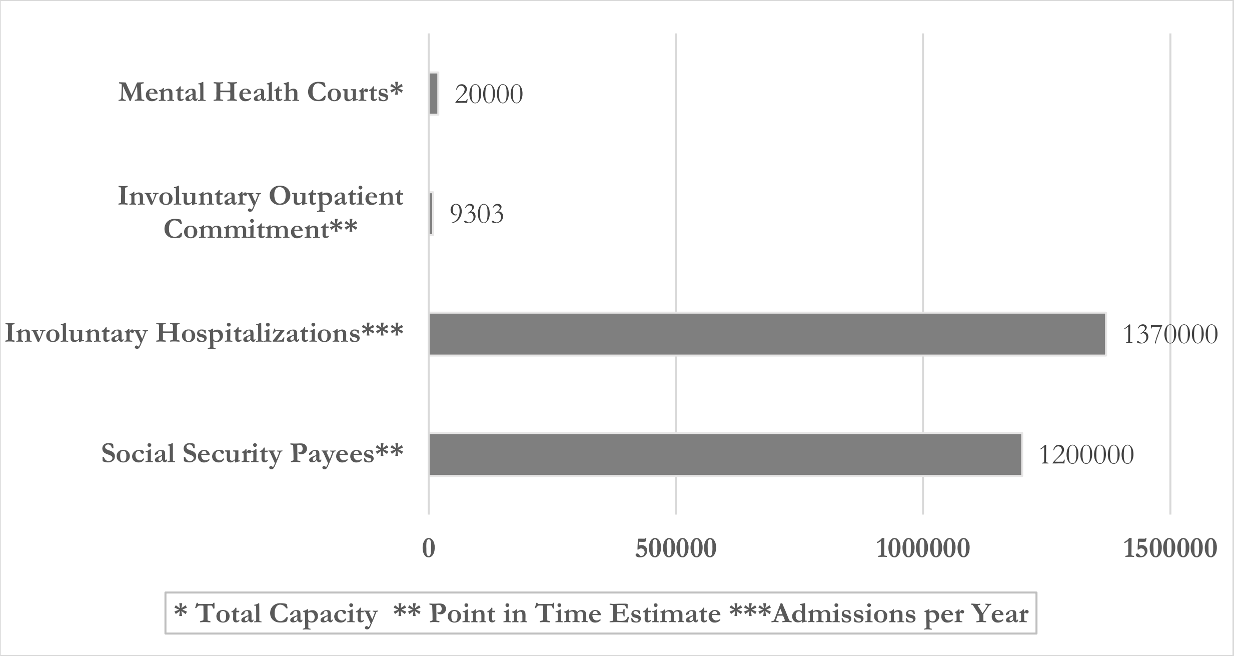
[116] President's New Freedom Commission *Achieving the Promise.*

[117] Those were California, Massachusetts, Colorado, and Florida; I was able to make an estimate for New York based on an interview. Kimberly Nielsen deserves an enormous thank you for her work on this ultimately disappointing exercise.

Figure 0.14: Forms of Formal Legal Coercion in U.S. Mental Health



Sources: Estimates for IOC from Meldrum et al. (2016); Social Security Payees from Monahan et al. (2011:1199); Mental Health Courts from SAMHSA "Mental Health Treatment Court Locator" (https://www.samhsa.gov/gains-center/mental-health-treatment-court-locators); hospitalizations from Miller and Hanson (2016) who cite Kirk et al. (2013) who cite Gomory et al. (2011), who just extrapolates from California and Florida. So, no one knows, really.

risk is not just about protection, but maximizing potential (Broer and Pickersgill 2015; Rose and Abi-Rached 2013). For example, the finding that neurological warning signs of schizophrenia can be detected earlier than symptoms provides grist for arguments that psychiatry should be permitted to intervene sooner, in the name of preventing full-fledged dangerousness and disease (Bennion 2013).

In this new regime of constraint, the mentally ill themselves are supposed to participate in the management of risk. At least analytically, the binary in-out coercion of involuntary hospitalization has been replaced by techniques like involuntary outpatient treatment, in which a person is required by a court order to take medication, or risk being brought back to a hospital for evaluation. These new modalities allow for "governance through freedom" (Gong 2017) because the persons themselves decide whether to comply with their medication regimen. Indeed, the dominant discourse of "recovery" precisely that even the sickest patients can manage risk themselves: providers should allow them to "take some risks with [their] choices" and "live with [their] consequences" (Jacobson and Greenley 2001:484). From this perspective, "overt use of coercion has likely been replaced by more subtle forms of social control in modern psychiatric practice" (Perry, Frieh, and Wright 2018:108; see, also, Novella 2010; Zetterberg et al. 2014). Far from serving only to pacify the mad, modern psychiatric coercion creates "self-reliant, autonomous citizens…capable of self-control and choice" (Bagnall and Eyal 2016:42).

I argue in Chapter 4 that these perspectives confuse the official directives of the mental health system with its actual functioning. In many cases, coercion was not so much soft and subtle as it was stochastic and spectacular. In New York, someone might be out of compliance with their court order to take treatment on an outpatient basis, relatively unmolested, for months, until the sheriff's "removal team" assigned to such clients finally got around to tracking them down, placing them in handcuffs, and bringing them to the emergency room. There, in the absence of a hospital bed, clinicians might tie them down, give them an injection, and release them. Even for those who made it into the hospital, psychiatrists in the U.S. were expected to regularly assess "risk" using formalized tools, but managed care insurance companies could abruptly tell them to discharge patients regardless.[118]

I analyze commitment hearings in France and the U.S. not to show how medicine and law combine their powers to produce "self-governing subjects," but how, through a mix of collaboration and conflict, they push patients to become "serviceable objects." In his analysis of the asylum, Goffman (1961:379) describes the series of ritual degradations a patient must go through to "become a kind of object on which a service can be performed." A psychiatric patient is "serviceable," I argue, when some professional group can claim jurisdiction over intervening in that person's life, that intervention is rendered institutionally legitimate, and the patient provides the minimum level of cooperation to keep moving through the system. Although modern hospitals do not look like the "total institutions" described by Goffman, his insight that they rarely look for the "cultural victory" of true transformation, and instead only the "management of men" (Goffman 1961:13), rings true.

What makes a patient "serviceable" differs between France and the United States. In France, the courts aim to produce "suffering citizens": persons who passively consent to the solidarity offered to them by the medical representatives of a (diminished) welfare state. In the U.S., their homologues are "compliant calculators." These serviceable objects have enough rationality to align their desire to get out of the hospital with the hospital's aim of containing danger at minimum cost. Of course, when the "objects are human beings…the object always has to be conquered against the specific resistance of living and sense-making individuals" (Hirschauer 1991:314). Some patients in France refuse to ever consent to the free, indefinite services offered to them; some in the U.S. never make the rational call that they would be better off taking their meds. Rather than becoming even more tangled in the net of disciplinary power, though, I show how those individuals are simply temporarily expelled from the mental health system as "unserviceable." The chapter thus relates to previous ones in highlighting cases that national "repertoires" of classification struggle to make sense of and that defy the coupling of knowledge, judgment, and intervention behind state kinds.

Conclusion: Mental States

Durkheim (1957) described societies as a kind of "natural despotism" that molds individuals into obeying a "collective type." The severely mentally disordered present a chance to see what happens when the states that act as guarantors of that despotism run up against individuals who, willfully or not, disobey shared expectations of rationality and self-control. This dissertation thus seeks to show how, in practice, states (attempt to) mold the subjectivities of their citizens and, when all else fails, settles for "objectivation," the "deal[ing]…with men as things" (Bourdieu 2015:214).

I argue that differences in the ultimate social status of the severely mentally disordered depends much less on explicit policy, and more on the way that states divide up professional jurisdictions, set boundaries between health, social, and judicial institutions, and give state agents toolkits of classifications that they deploy when they encounter disordered individuals. As I show, amidst the madness of mental health policy, there is method; coherent, long-running, and nationally-specific patterns of ordering the disordered.

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[118] A similar critique of taking discourses of "calculated risk" and "cost-benefit rationality" at face value is made by Gowan and Whetstone (2012).

Chapter 1: Ration or Rationalize:
Allocating Psychiatric Care in the United States and France

Health systems face intensifying pressures to economize medical treatment, driven by expensive technological advances and a shift in the burden of disease from acute to chronic conditions (Hoffman 2012; Light and Hughes 2001; Livne 2014, 2019). The challenge of allocating medical resources is particularly acute in mental health systems.[1] First, in the absence of clear bio-markers or definitive diagnostic tests, the boundaries of mental disorders—and thus of the need for treatment—are fluid and contested (Horwitz and Grob 2016; Mechanic 2003; Rosenberg 2006). Second, demand for mental health care is elastic. Simultaneous promises that therapy and psycho-pharmaceuticals can make people "better than well" or help them deal with difficult non-medical social circumstances encourage consumption of treatment in a way that advances in dialysis or chemotherapy do not (Glied and Frank 2016; Rose 2006b). Finally, the economization of mental health care is partly constrained by the system's parallel mandate, alongside treating symptoms, to manage disruptive or deviant behaviors and contain risks (Brodwin 2012; Gong 2017).

This chapter analyzes the allocation of care in public mental health systems in France and the United States.[2] In each country, the public system faces pressure from below in the form of expanding demands for treatment and from above as policymakers and regulators attempt to balance care with costs and imperatives of social control. While the public system serves 3.4% of the adult population in France and 2.2% in the United States[3], these aggregate figures do not capture the different ways that these two systems respond to these challenges. In coherent and consisting ways, each country constructs the universe of people potentially deserving of publicly-financed care, creates rules for that care's allocation, assigns and withdraws it in practice, and ultimately excludes some potential beneficiaries entirely in distinctive ways. Yet the result is paradoxical: in the U.S., the public mental health system embraces a broader mandate for reducing distress in the population and uses a wide range of strategies to encourage people into care. It nonetheless manages to control both costs and case-files. The French construct a narrow orbit for their mental health system and wind up dealing with a greater number of people on a long-term, recurrent basis.

Drawing on interviews, archival materials, and ethnographic observations, this chapter examines the institutional logics—the set of cognitive categories, discourses, and values that structure action in complex organizations (Friedland and Alford 1991; Haveman and Gualtieri 2017)—shaping allocation decision in public mental health care in France and the U.S. While a literature on institutional logics in health care demonstrates that multiple, co-existing conceptions of the goals of care within a single organization can produce fragmentation and discord (Cain 2019; Dobransky 2014; McPherson and Sauder 2013), I find that even professional disagreement in each country is structured by an overarching logic. In France, care is "rationed" by clinicians who have a

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[1] I use mental health "care" rather than "treatment," as the "care" being allocated could include services, like case-management, employment support, and housing, which extend beyond the pharmaceuticals or talk therapy classically associated with mental health "treatment."

[2] The boundaries of "public" are intuitive in France, where "public" psychiatrists are employees of the state and the public system is given specific mandates in public policy, like delivering involuntary treatment, excluded from the orbit of a large system of private providers and hospitals. "Public" in the U.S. refers to specialty mental health services provided by states, either through general Medical programs or through "carve outs" that establish funding streams specific to mental health (or, increasingly, "behavioral health," which includes addiction).

[3] For France, see Lopez and Turan, *Organisation et fonctionnement du dispositif de soins psychiatriques*. The number for the U.S. is from the SAMSHA Uniform Reporting System 2017. Retrieved March 27, 2019 (https://wwwdasis.samhsa.gov/dasis2/urs.htm).

Table 1.1: Logics of Allocation in France and the United States

	France – Rationing	***United States - Rationalizing***
Constructing the Object of Care	Limited use of public health techniques (epidemiology, prevention, public awareness); concern that "mental health" detracts from "care."	Heavy use of public health techniques; mental health campaigns as a way to *avoid* spending on mental illness.
Regulating Delivery	Limited regulation: psychiatrists successfully argue care cannot be standardized, cut into discrete acts for payment, or objectively evaluated.	High regulation; psychiatrists embrace managerial and accounting techniques.
Allocating Care	Categorical divisions; keeping care from those with 'psychic troubles' problems to deliver it to those with 'real illnesses.'	Continuous; calibration of care based on perceived level of functioning and ability to access services elsewhere.
Problematic Populations	Individuals with 'psychic troubles' (not real mental illness) that are severe or who are economically precarious.	Individuals who are typologically different from the mentally ill (addicts, personality disorders) but for whom there is public pressure to provide behavioral management.
Excluded Populations	People with addictions or judicial involvement who are seen as typological different from people with both 'psychic troubles' and 'mental illness.'	People with severe symptoms who are not high users of services or disruptive (frequently, women).
Withdrawal of Care	Care is indefinite; people die and disappear, but care is rarely actively withdrawn.	Care is always time limited, and the removal or stepping down of care is a key metric of system success, although rarely achieved.

vague mandate and few clear guidelines for realizing it. They exercise discretion following a simple categorical scheme, excluding people whose problems they see as not properly psychiatric, limiting care given to people who have mere "psychic troubles," and maximizing the amount of their scarce resources delivered to "real *malades* [sick people]."[4] In the U.S., the allocation of care is "rationalized." Clinical time and resources are carefully calibrated following elaborate criteria in order to achieve a clearly-defined mission (see Table 1.1). As I show, these distinctive logics result in divergent sets of classificatory conundrums for mental health providers and exclude a different set

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[4] The semantic distinction here is important, but difficult to translate. In France, "*malade*" is a noun, not a modifier. Mental illness can be, linguistically, not just an attribute, but a type of person.

of potential patients: the disruptive but not evidently ill in France, and the ill but not particularly disruptive in the United States.

The comparative approach and specific focus on public mental health of this chapter allows me to make several theoretical interventions. First, the literature on the rationalization of health services has emphasized the importance of professional resistance in determining the success or failure of techniques like managed care, evidence-based medicine, or economization (Freidson 1973; Starr 1982; Timmermans and Oh 2010). In explaining why rationalization has become pervasive in the U.S. while faltering in France, despite the historic power of the American medical profession, I show how an altered elaboration of the goals and nature of mental health care in the U.S. has actually conscripted professionals into the rationalizing process. The adoption of the idea that mental illness exists on a continuum along which any individual can (and will) move makes the withdrawal of care not just a cost-saving measure, but a moral necessity (Livne 2014, 2019). In France, rationing appears to professionals as the only option because mental health care is too subjective to evaluate and mental illnesses too chronic to contemplate withdrawing care.

Second, in examining how each logic came to dominate, I clarify the relationship between "rationalization" and "medicalization," the latter typically defined as the "process by which nonmedical problems become defined and treated as medical problems" (Conrad 2007:4; see, also, Clarke et al. 2003; Jutel 2011). The "medicalization" and "rationalization" of mental health services have typically been presented as advancing hand in hand (Scheid 2004), but, as Showalter (2019) points out, at what level "medicalization" is taking place is often unclear. I disaggregate the concept and find that, in the U.S., rationalization has depended on *institutional medicalization,* or the integration of the mental health system into the broader health system. This has facilitated the incorporation of rationalizing techniques applied to more traditional forms of health care. But, paradoxically, I show that at the ground level, rationalization has relied on *normative* and *cognitive de-medicalization*: the re-construction of the goals and modalities of mental health care away from traditional medical understandings of "treatment" and "cure" towards reducing service use and controlling behaviors. In France, rationing is underpinned the institutional separation of the public mental health system from the medical system writ large (and thus insulated from its overall rationalization) but the maintenance of the idea that it should deliver "medical" care towards the goal of addressing pathology and symptoms. As such, if rationalization and medicalization appear to be linked logics, this chapter pulls them apart to show how medicalization at a systemic level facilities rationalization and at ground level makes such rationalization difficult.

This chapter proceeds as follows. In the literature review, I lay out the traditional strategies of rationing in healthcare systems and the growing push to replace those practices with techniques of rationalization. I explain why scholars once saw mental health care as resistant to rationalization and theorize how this resistance was overcome. After explaining my methodology, I examine the logic of rationing in France: the resistance to rationalization at a regulatory level, the construction of a narrow object of public mental health care, the strategies used to allocate care to that object, and the way that a lack of rationalization ultimately led to an ever-expanding caseload. I follow the same pattern for the U.S., showing the gradual ascendancy of rationalizing managed care and a broadening public health mandate in contemporary New York before pivoting to show the practical rationalization of care in California, where managed care is longer established. In the conclusion, I reflect in particular on how the analysis of *public* mental health care adds to the existing literature on rationalization and economization in health systems.

Literature Review

From Rationing to Rationalization

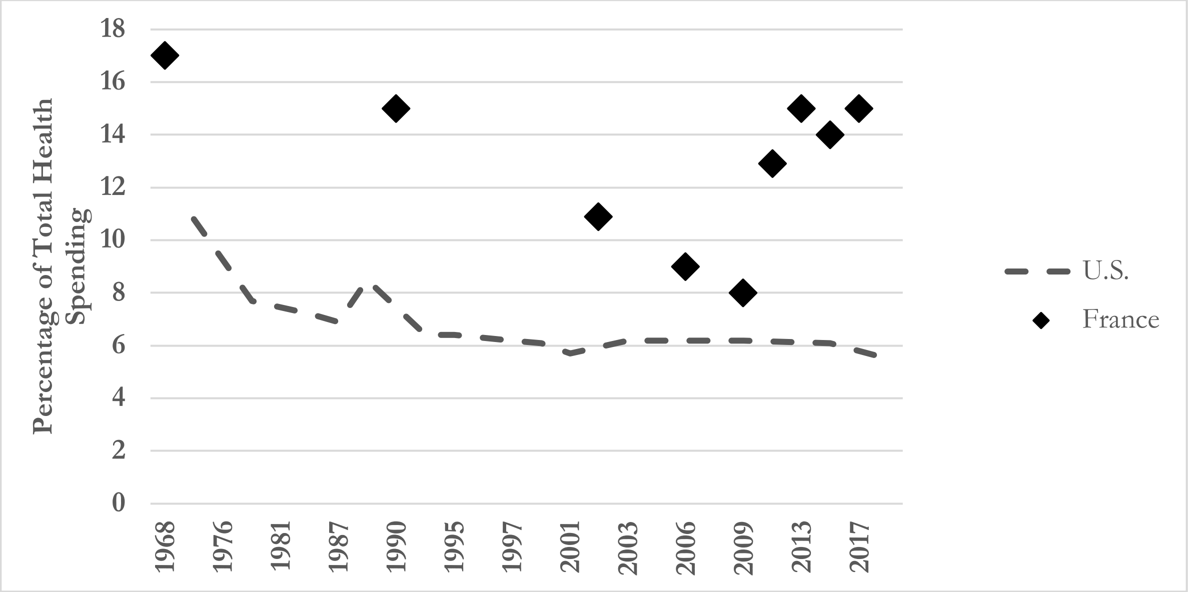
In the 19th century, an over-supply of doctors struggled to sell a surfeit of medical care to people that rightly distrusted their wares (Starr 1982); nowhere was this more true than in psychiatry, where a near-totality of asylum patients were treated involuntarily (Eyraud and Moreau 2013:128). In the 20th century, in the face of the pincer pressures of advancing medical technology and a population increasingly convinced of its value, "rationing" has become "increasingly evident in all medical systems" (Mechanic 1995:1655; see, also, Lipsky 2010:34; Wilkerson 2003:338). In simplest form, "rationing" is the "control and limitation of the consumption of a product or service" (Hoffman 2012:xv) whose supply is finite. Rationing results in some people foregoing something that would at least hypothetically be useful or desirable (Schmidt 2004:970).

Rationing of medical care became more complex as states established rights to health care that were often more universal and more extensive than those for other public services (Carpenter 2012). Rationing in mental health care took on a particular flavor in both France and the United States in the 1960s as new community clinics were "expected to meet the needs of geographically defined populations with limited resources" (Scheid 2004:67; for France, see Eyraud and Velpry 2012; Henckes 2010). But rationing in public mental health care came neither through the market nor through a clearly circumscribed mission in policy. Instead, it thus was often "implicit" in non-codified but widespread practices at the micro-level (Mechanic 1995), like constructing long waiting lists or shunting clients off onto other agencies (Finlay et al. 1990; Schwartz 1975). The logic of rationing thus privileges "local theories of justice" as professionals divide between clients deemed as deserving or underserving, urgent or not, "sick" or just "bad" (Brodwin 2012; Dobransky 2009; Vassy 2001)

Efforts to make medical decision-makers accountable and transparent are part of a broader push to rationalize medical services. Rationalization, Weber (1978:339) argues, entails the effort to achieve a given end efficiently through the use of science, technology, and calculation. It also reshapes the ultimate ends of medical systems to be "productivity, minimization of financial costs, optimization of resources, and 'outcome targets'" (Quah 2014:2). As a logic, rationalization overcomes the "tension between knowledge and values" (Moreira 2011:1333) visible in rationing, because these ends are served simultaneously by the application of economic and managerial expertise (Benamouzig 2005). In health care, the most iconic vessels of rationalization have come from managed care insurance companies, which limit the network of providers of medical care, subject its delivery to "pre-authorization," and conduct ongoing "utilization reviews" (Casalino 2004; Scott et al. 2000). More than simply seeking to economize or privatize care in aggregate, then, rationalization depends on penetrating medical practices through accreditation, evaluation, and evidence-based guidelines (Cohen 2017; Juven 2018).

Historically, scholars have thought that mental health care is—for better or for worse—insulated from the pressures of rationalization. As the doyen of theories of the ever-expanding rationalization of the social world John Meyer (1985:595) claimed, "The striking aspect of the mental health system is that there are no consensual institutional rules defining people as healthy or sick, better or worse, or for differentiating between a clearly successful treatment or a failure." As my French informants will argue, the population of "mentally ill" is too difficult to pin down, the trajectories of their illnesses too haphazard to model actuarily, and the outcomes of intervention too subjective to evaluate (Benamouzig 2005; Dinitz and Beran 1971; Marmor and Gill 1989). At least some economists agree: "The care of people with mental illnesses responds differently to economic forces than general health care does, for reasons that have to do both with the nature of these illnesses and with the nature of the service delivery systems that responds to these inherent

Figure 1.1: Mental Health Expenditures as a Proportion of Total Health Expenditures (1968-



Note: There is no continuous data series for France. These ratios reflect differences in what counts as mental health treatment (for example, anxiolytic medications) and what is counted as part of the health system (for example, payments for long-term sick leave). I have thus not 'connected the dots' for France.

Source: Substance Abuse and Mental Health Services Administration, *Mental / Behavioral Health United States;* for France, Benamouzig (2005), Bousquet (2016); Chevreul et al. (2013); Heijink, Richard and Thomas Renaud. 2009. *Études de coûts par pathologie : une comparaison méthodologique entre cinq pays.* n° 143. Institut de recherche et documentation en économie de la santé; Milon, Alain. 2012. *La prise en charge psychiatrique des personnes atteintes de troubles mentaux.* n° 249 : Sénat; Lopez and Turan, *Organisation et fonctionnement du dispositif de soins psychiatriques*; World Mental Health Atlas; Joly, Pierre. 1997. *Prevention et soins des maladies mentales.* Paris, France: Conseil economique et social.

characteristics" (Glied and Frank 2016:544). Concluded Brown and Cooksey (1989:1130) a decade into the managed care revolution, "the mental health system has…been far less subject to…rationalization forces" than the health system writ large.[5]

Rationalization and Medicalization

Just a few decades later, the literature on the U.S. paints a very different picture. Psychiatric care was "more severely walloped by managed care policies than any other branch of medicine" (Luhrmann 2000:243) (see Figure 1.1). In the literature, mental health professionals describe obtaining onerous authorizations for care, submitting to overbearing guidelines for best practices and documentation, and conceding to insurance by discharging patients as fast as possible as pervasive elements of their professional lives (Horton 2006; Kirschner and Lachicotte 2001; Rhodes 1991; Scheid 2004).

What explains the shift? Scholarship has emphasized how rationalization must overcome traditional deference to medical professionals to move decisions about care "from solely a professional determination to an administrative judgment" (Mechanic 1995:1656; see also Boyd 1998; Reich 2014a). My comparative analysis identifies two other conditions for the successful rationalization of mental health care. First, mental health care must be cognitively and

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[5] Indeed, Scott et al's (2000:40) classic study of changing logics in health care actually excludes psychiatric hospitals from analysis as organizationally too distinct.

administratively *reconstructed as something that can be rationalized.* The barriers to rationalization cited above—that mental health care is too subjective to be protocolized, that the prognosis and costs of a given condition is impossible to project, or that the outcomes of an intervention could not be measured—made community mental health a "boundaryless" system as of the 1970s (Dinitz and Beran 1971). Part of rationalization, then, has been re-bounding community mental health within the health system. In the U.S., I show how, at a macro-level, mental health care was redefined as commensurate with health care writ large, which in turn meant that it could be subjected to the same rationalizing techniques.[6] I refer to this greater integration of the mental health field into the field of health care as *institutional medicalization*.

Yet, paradoxically—and contrary to studies that claim a straightforward relationship with "medicalization" (Chaufan et al. 2012; Clarke et al. 2003)—I show that rationalization also rested on a partial de-medicalization of care. In the U.S., the goals of psychiatric treatment were reframed as objectively-measurable changes in behavior or service use, rather than inner, subjective transformation, and the work of mental health professionals reframed as providing discrete acts of assistance rather than open-ended psychotherapy or even medication management (see, also, Gong 2019). This shift in goals and practice constituted *normative* and *cognitive de-medicalization*, insofar as clinicians reason through non-medical categories (like "service use" rather than "pathology") and seek non-medical ends ("behavioral control" rather than "symptom reduction").

The "normative" dimension, I show, is key. Previous work has emphasized how, even absent overt resistance to rationalization, clinicians can work around the requirements imposed on them by insurance companies or accreditation agencies (Kirschner and Lachicotte 2001; Rhodes 1991; Whooley 2010). My research, however, shows how clinicians came to rationalize their own exercise of discretion, because the economizing and withdrawing care became synonymous with that care's own success. Rationalization, like any economic process, "is not simply a product of an imbalance between supply and demand" but also "shaped by a layering of cultural beliefs" (Light and Hughes 2001:552) that imbue seemingly mundane acts like filling out grids to track symptoms or calling insurance companies with meaning and significance. An understanding of rationalization as purely a matter of cold economic calculation misses the way that, in contemporary American healthcare, rationalization has also become a moral imperative (Horton 2006; Livne 2014, 2019; Reich 2014a). This chapter thus builds on Haveman and Gualtieri's (2017) admonition for the study of institutional logics to include an emotive dimension; it is precisely because rationalization comes to be seen as the best way to achieve goals elaborated outside of it, like promoting "recovery," that makes it such a powerful organizing force.

Data and Methods

The primary data from France for this chapter come from observations of a *Centre médico psychologique* ("Medical-Psychological Center," hereafter CMP) serving an *arrondissement* ("district") of Paris. The CMPs were baptized in 1986 as the "unities of coordination in an open milieu, organizing actions of prevention, diagnosis, ambulatory care, and home intervention, at the disposition of a population."[7] The CMP's mission is close to that of the Community Mental Health Centers that were similarly central to de-institutionalization in the U.S. (see Grob 1991), albeit with the important

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[6] This was the flip side of attempts to achieve mental health "parity" in insurance coverage, which professionals and advocates saw as a more unequivocally positive form of institutional medicalization (see Hernandez and Uggen 2012).

[7] Ministère des affaires sociales et de la solidarité nationale. *Arrêté du 14 mars 1986 relatif aux équipements et services de lutte contre les maladies mentales, comportant ou non des possibilités d'hébergement*. Paris, France.

caveat that the CMP was part of a single administrative unit, the *secteur,* which also included hospitals (see Introduction).

The CMP I studied had two full-time doctors, two social workers, a psychologist, and a dozen nurses; some of the other doctors of the *secteur* who also saw patients in the hospital rotated through the CMP to see those patients upon discharge. In addition to hundreds of weekly consultations for an active file of nearly 2,800 patients, the CMP received patients in emergency situations, carried out home visits, distributed treatments, and dispatched nurses to visit (often dying) patients in the general hospital of the neighborhood whose doctors thought needed a psychiatric consultation.

Over the course of seven months, I attended weekly meetings in which the team of the CMP discussed new patients. Although there was no official regulation or guidelines for intakes[8], the CMP I observed follow a procedure similar to that described by interviewees from other *secteurs*. People who called the *secteur* asking for an appointment were first received by a secretary, who confirmed their address and set a meeting with a nurse (people contacting the *secteur* about a third party were a different matter, discussed below). Although the nurse would fill out an extensive intake sheet, they would pare it down to a one- to two-hundred-word summary. These summaries, around fifteen per week, would then be compiled into a single document and combined with reports on the *secteur*'s home visits, responses to urgent cases, and the patients seen in general emergency rooms, which the team discussed each Friday. Nurses would present each patient and one of the psychiatrists would decide whether the patient would be seen in the *secteur* and with whom. All told, I observed the discussion of 260 new patients who presented for a meeting with nurses and 79 who were seen in an emergency context. The most serious patients would also be assigned to see a social worker; I attended the social workers' weekly meetings as well as ongoing meetings where the nurses discussed difficult patients with the head psychiatrist.

Data gathering in the U.S. was split between New York and California. New York provided a strategic opportunity to analyze the rationalization of mental health care. On one hand, the state was in the midst of redesigning Medicaid to control costs and service use through private managed care insurance companies. On the other, New York City's "Thrive" initiative aimed at expanding access to precisely that system being rationalized by Medicaid redesign. To understand the transition to managed behavioral health care, I reviewed the archives of the state's Behavioral Health Reform Work Group and interviewed three of its participants. I also interviewed two officials in the state Office of Mental Health who had a major role in implementing reform, two psychiatrists who worked for managed care companies, and twenty providers who were experiencing the managed care transition. These same individuals, combined with a half-dozen people throughout city government working on specific aspects of Thrive, also spoke to that program's impacts. I supplemented these interviews by reviewing the substantial media coverage on the initiative.

My ethnographic observations for the U.S. come from a public clinic in California where, over the course of a year, I attended weekly Level of Care meetings. At these meetings, a licensed clinician dedicated to performing initial intakes would present new cases to the heads of the Clinic's four treatment teams, who would collectively decide (following a set of formalized tools) where to assign the client.[9] I observed a total of 78 discussions of new cases, 80 decisions over changes to level of care for existing clients (including closures), and 163 status updates about difficult clients. The balance of professional power was quite different in California than in France; the treatment

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[8] Mission nationale d'expertise et d'audit hospitalier. 2008. *L'organisation des centres médico-psychologiques*. Paris, France.

[9] In France, the team almost always spoke of "patients"; in the U.S., "clients." I follow their terminology in part because it emphasizes the more medicalized approach that French clinicians took at the ground level.

teams were headed by people trained either as clinical social workers or psychologists, and with a single psychiatrist participating without assuming a leading role. The four levels of care in the clinic served a total of around 400 clients.

The CMP in France and the Clinic in the U.S. were each the primary public mental health provider for a catchment area of around 150,000 [I am withholding further details to keep my field sites dis-identified]. The areas they served were relatively affluent, albeit with significant pockets of poverty. They operated in zones with a large number of private mental health providers, meaning that public clinics were not the sole option for patients (in stark contrast to many rural areas in both countries). They both also functioned in a zone where municipal governments were aggressively pushing for the public mental health system to expand its reach. In France, the pressure was for psychiatry to play a greater role in resolving problems in public housing and preventing Islamic radicalization; in California, the demand was that the Clinic to do more to address the perceived disruptive behavior of homeless people and prepare for people released from prisons.

I do not claim that the CMP and the Clinic are "comparable" in terms of the population they serve or their place in the institutional landscape. Whereas the CMP in France was one piece of a *secteur* that also included hospital beds, therapeutic apartments, and a day hospital, the Clinic depended on the criminal justice system or private hospitals to manage its most difficult clients and had to lean on external social service agencies to provide housing. The population of the Clinic is more male, more psychotic, likely more racially skewed, and vastly more economically precarious than that in France (see Table 1.2). What these two sites do share is that each was tasked with providing "public mental health care." It is precisely the process of filling in what "public" and "mental health care" mean—both in public policy, in interaction between institutions, and within the clinical teams themselves—in a resource constrained environment that I seek to investigate.

France: Rationing for the 'Real *Malades*'

Regulating: The Irrationality of Institutional De-Medicalization

The French literature on public psychiatry has emphasized the gradual intrusion a logic of rationalization into public psychiatric care (Biarez 2004; Demailly and Autès 2012; Dubuis 1999; Philippe 2004) The lived experience of psychiatric professionals was tightening cost controls, new demands for documentation from "paper-vores" (Interview, 7/12/16) in the ministry, intrusive external evaluations, pressure to standardize treatment in line with evidence-based guidelines, and an expectation of increasingly specialized and short-term care. From a comparative perspective, though, what is remarkable is how little these techniques from the medical system penetrated mental health care (*institutional medicalization*).

The design of France's public psychiatric system in the 1960s came at a time where the government was aggressively expanding the health system writ large (see Palier 2005). The original *sectorisation* document charged public psychiatry with an expansive mandate: assuring that "within each territory…all the *malades,* men and women, have an indispensable continuity of care between screening, treatment… and surveillance."[10] As the minister clarified it, "the *secteur* is, above all, an obligation for public services to accept and care for every patient that addresses it and resides in a given geographic area" (qtd. in Ayme 1995:442–43). Furthermore, *secteur* care would be distinctive in that it would be free for the patient at the point of service, rather than be reimbursed afterwards through social security. Noted one ministry official, "This question of access to care, it was decided with the *secteur* that there would be free care, and that's specific to psychiatry, you don't find it elsewhere" in the French health system (Interview, 3/28/16). Partisans of the *secteur* believed that,

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[10] MSPP, *Circulaire du 15 Mars 1960*: 2.

Table 1.2: New Outpatient Populations in the Clinic (California) and CMP (Paris)

		Clinic (California)	**CMP (Paris)**
Gender	*Male*	60%	39%
	Female	37%	61%
	Trans	3%	*
Race	*White*	40%	N/A
	Black	40%	
	Latinx	8%	
	Asian	5%	
	Other	6%	
Origin	*All Foreign*	N/A	28%
	North Af/Arab		12%
	African		3%
	European		7%
	Other		5%
Average Age		46	39
Diagnosis	*Psychosis**	52%	14%
	BiPolar Disorder	21%	4%
	Mood	22%	35%
	Personality	9%	5%
	PTSD/Trauma	14%	5%
	Other+	8%	9%
	None / Unclear	N/A	10%
Substance Use	*Any♦*	65%	30%
	Meth	30%	N/A
	Opioids / Heroin	0%	<1%
	Marijuana	37%	8%
	Alcohol	36%	16%
	Cocaine / Halluc.	9%	4%

* Includes Schizophrenia, Schizo-Affective Disorder, and Psychosis NoS, rarely differentiated in France.

+Includes Dementia, Intellectual Disabilities, Insomnia, Eating Disorders, Obsessive-Compulsive Disorder, and Somatoform Disorders.

♦In France, addiction could be a stand-alone condition: in the U.S., it was always coupled with another diagnosis. For the U.S., this includes only 'active' or 'recent' substance use; for France, it excludes use (almost always alcohol) deemed unproblematic or 'festive'.

because some psychiatric patients with psychosis were chronically unpleasant, disturbing, or uncooperative, there needed to be "an obligation, a bit legal, for the *secteur* to occupy itself with the people of the *secteur*…with no question of getting rid of the people that we don't want to occupy ourselves with" (Interview, 7/15/16). The ambiguity, however, was that this expansive mission was coupled with the idea that the "*malades*" the *secteur* would be treating were a small, bounded group. In the first "Congress of the *secteurs*" in 1966, for example, psychiatrists declared that the *secteur* was for "the most diminished and the most disturbing" (qtd. in Velpry 2008:93).

Still, the idea that psychiatry should rationalize its expenses and deliver more care, at higher quality, at lower cost has been present almost since the origins of *sectorisation.* In France, it is closely tied to parallel fears that there is no "abstract exteriority" of demands for psychiatric care, because "it is the offer of care that induces the manifestation of demands" (Murard and Fourquet 1975:321). By 1974 the ministry was insisting on the need for regulators to "become very strict in demanding justifications for expenses and to appreciate the results obtained."[11] With 25% of hospital beds and 17% of total health expenses, psychiatry was one of the first targets for a growing cadre of health economists in the central state. Yet they quickly determined that "the definition of 'results' is difficult due to the plurality of theories…definition and approaches" to mental illness (Benamouzig 2005:164) and subsequently moved on to applying their rationalizing techniques to the rest of the health system, largely leaving psychiatry out.

When the state began seriously grappling with the perpetual deficits of social security in the 1980s, it initially put both general and psychiatric hospitals under a "global" budget. For psychiatry, this meant that the hospital would receive a lump sum, and the director could then divide the money between the different *secteurs* attached to the hospitals, who could spend it relatively freely. Another head of a *secteur* celebrated: "We never have to stop treating someone. We can say 'treatment for life', and that means care but also accompaniment to rehabilitation, recovery. The patients are 100% taken care of, which means they don't have to advance any payment, because we have a global budget" (Interview, 6/28/16). But while a global budget served the ends of rationing by capping overall expenses, it gave external actors few tools to crack open the black box of medical practices to rationalize the kinds and quantity of care delivered (Divay and Gadéa 2008). One official explained that the "global budget" was a problem because "it separates psychiatry from the rest of medicine" and "is difficult for the management of hospitals" (Interview, 2/28/16).

Starting in 2008, the state shifted to paying general hospitals on the basis of their activities, which, in a context where public health spending was slowing, "transformed the economic logic of the hospital" and created an intensifying competitive quasi-market between them (Juven 2015, 2018). At least in the early 2000s, the idea was that psychiatry would follow suit. "Tarification by the activity" (T2A) was a potentially powerful tool for rationalization because it would "link the allocation of funds to the care produced and the sick treated in a *secteur*."[12] The development of T2A, however, required the construction of "homogenous groups of *sejours*" (see Pierru 2012)—categories that typologized mental health problems by the relatively standardized protocols for treating them in discrete episodes. The average costs would then become the basis for payments to hospitals.

Psychiatrists overwhelmingly opposed the move: the leader of one psychiatric union reported that 80% of his membership voted against T2A (Interview, 8/3/16). Professional organizations mobilized around the argument that their work was impossible to put in the economizing framework of the rest of the health system. First, as one hospital director explained, "two schizophrenics…are going to have a trajectory of treatment and an intensity of care that is simply not the same, so you cannot construct homogenous groups on the basis of diagnosis" (Interview, 8/18/16). Some psychiatrists deliberately exacerbated this managerial challenge by declaring a "strike against statistics" in 2004, coding most cases into electronic heath records reviewed by the ministry as "F99: psychic troubles without other indicators" (Bélart and Dembinski 2012:162). Presenting the mentally ill to the authorities as a homogenous mass—even as, of course, psychiatrists in practice modulated treatment for different patients—made constructing categories for the T2A impossible.

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[11] MSPSS, *Circulaire DGS/891/MS 1 du 9 mai 1974*: 7.

[12] Massé, *La psychiatrie ouverte,* 224.

Even deeper than these technical challenges, though, the mission of public psychiatry itself was a barrier to institutional medicalization. The *secteurs* were, after all, charged with providing a holistic medical response for the severely mentally ill, which cut against the logic of payment by the act applied in other disciplines. One official explained, "the chronicity of the illness, the notion of intervention to preserve human relations, the idea of rehabilitating rather than curing someone, the need to follow the person over time… all these things mean the T2A is not adapted" (Interview, 6/22/16). It was difficult to imagine, for example, how to code and account for time psychiatrists spent liaising with police or working with involuntary patients to accept treatment.[13] By 2006, the government had concluded that "the T2A in psychiatry poses methodological problems that are not resolved"[14] and abandoned the project.

Of course, with a global budget, the ministry could control public psychiatry's overall expenses, and as of 2015, the *secteurs*' budgets were unchanging (even as demand for their services was increasing). What they did not do, however, was curb the discretion of each *secteur* in how to spend it and on whom. The clearest any official government text got to defining who should actually be cared for in the *secteur* was a *circulaire* in 1990 stating that "public psychiatry will necessarily…be in charge of an [economically] diminished population that is…the most invalidated by illness."[15] But the government's 2016 report on the future of psychiatry reminded readers that the *secteur,* "as a public service, is obligated to receive every user addressed to it."[16] I asked the referent for mental health in the High Authority of Health, the government body responsible for elaborating best practice guides, who regulated who was treated in the *secteur*. She replied, "Uhh, I would say, first, no one… We're dealing with clinical practices…the administrative decision of classifying and orienting people is not part of our job…There is a principle of medical judgment that still prevails" (Interview, 2/22/16). Ironically, this "medical judgment" was being curbed substantially throughout the health system, but *not* in psychiatry.

Moreover, there was little regulation of what happened to patients once they entered the *secteur*. No official criteria existed for who should see which of the *secteur*'s key professionals (psychiatrists, nurses, social workers, or psychologists) or how often. Even as evaluation and evidence-based medicine has gradually entered French medicine more generally (Robelet 1999), one consultant still felt confident telling me, "There are basically no indicators used in psychiatry…It's not in their culture" (Interview, 5/10/16). Professionals continued to mobilize the discourse that the nature of mental illness made straightforward evaluation of outcomes impossible. For example, in response to a request from the ministry, the French Federation of Psychiatrists—the main academic organ of the discipline—proposed a list of 250 criteria for evaluation, which it stated could be grouped into a mere 26 categories (Interview, 8/3/16). Even the psychiatrist responsible for coordinating the experts that elaborated recommendations at the High Authority of Health voiced skepticism of most potential indicators: "For me, the definition of care in psychiatry is to aid a patient to recover spaces of psychic liberty…That he constructs his own life and not others in his place. I have a hard time saying how someone should live, otherwise it's normalization" (Interview, 3/1/16). The government auditor lamented that, even in 2011, "evaluation" in psychiatry continued

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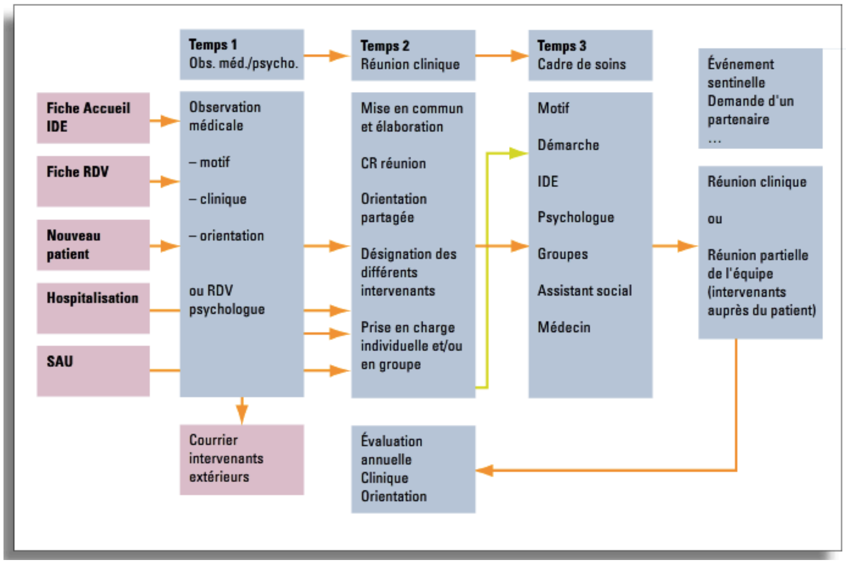
[13] Of course, in the U.S., many of these activities can't be billed for, and as such, are increasingly being abandoned.
[14] Rolland, Jean-Marie. 2006. *Rapport sur la tarification à l'activité dans les établissements de santé*. N° 3265. Paris, France: Assemblée Nationale: 21.
[15] MSSPS, *Circulaire du 14 mars 1990* : 73.
[16] Laforcade, *Rapport relatif à la santé mentale*: 88.

Figure 1.2: A flow-chart for the CMP, with no mention of patients leaving



Source: MNEAH, *L'organisation des centres médico-psychologiques.*

to mean summing up the number of consultations or prescriptions given, with little-to-no analysis of the effects those interventions produced.[17]

Finally, there was no discussion of when someone should *leave* the *secteur's* care. A 2008 best-practices guide for the CMPs explicitly noted that "the attentive reader will realize that if the management of entry is rather significantly raised, the question of the end of care is not even mentioned."[18] The report includes a flow-chart of a patient's potential trajectory through the CMP, which ends only with a comment that there should be an annual evaluation (Figure 1.2). One psychiatrist reflected at the end of a long career in public psychiatry:

> The access to care in France, it is pretty incredible. The organization of continuity of care is something extraordinary. We are capable, really, of caring for a psychotic for 20 years. That's amazing. During 20, 30 years, you're getting care in the same place. Really (Interview, 7/20/16).

The lack of *institutional medicalization* at the national level extended to the ground, which allowed professionals to maintain a vision that their role was to provide continuous medical care for a chronic illness.

In short, regulators failed to reconstruct the object of psychiatric treatment in a way that would allow it to be subjected to the same rationalizing techniques as the health system writ large. If the *secteurs* guarded their autonomy, though, they no longer lived in the glory days of expanding resources. Budgets were stagnant—which really meant declining, vis-à-vis the inflating costs of medication and personnel. In fact, the number of personnel in the *secteurs* has been static since 1989,[19] despite, as I discuss in the next section, pressures for them to expand their ambit. The state provided them no official rules or criteria that would allow them to refuse certain patients or step

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[17] Cour de comptes. 2011. *L'organisation des soins psychiatriques : les effets du plan « psychiatrie et santé mentale ». Rapport publique thématique*. Paris, France.

[18] MNEAH, *L'organisation des centres médico-psychologiques*: 99.

[19] Coldefy, Magali, Philippe Le Fur, Véronique Lucas-Gabrielli, and Julien Mousquès. 2010. *Dotation des secteurs psychiatriques en perspective avec le recours à la médecine générale et à la psychiatrie libérales d'Île-de-France*. n° 548. Paris, France : Institut de recherche et documentation en économie de la santé: 61.

them down to care, leaving them to a logic of rationing that drew on their particular definition of "public" psychiatry, and their sense that the *secteur* existed above all for the "real *malades*."

Constructing: Guarding the 'Real Malades' from 'Santé-Mentalism'

The pressure on the *secteurs* was not just budgetary, but also came in the form of calls for it to move from addressing "mental illnesses" to "mental health." Advocates making this discursive shift envisioned three concrete changes. First, rather than focusing on the "mentally ill" as a small, bounded group, policy should address a continuum of mental health that included a much broader range of the population who did not suffer from identified pathologies but nonetheless were in "psychic suffering" (see Ehrenberg 2005). The referent for mental health in the Ministry of Health was explicit in stating that "the position of the ministry is that mental health goes from well-being to mental illness. The only difference is the gradation" (Interview, 5/10/16). Second, addressing mental health entailed another form of *institutional medicalization:* the embrace of tools of public health, including epidemiology, prevention, and public de-stigmatization campaigns.[20] Third, mental health was not just the affair of psychiatry alone, but required it to interact with municipal governments, the police, and social service agencies. Given both their finite budget and their understanding of the responsibilities of public psychiatry, many in the *secteurs* resisted a move towards mental health that would expand their charge, and they found allies throughout the system for other actors committed to serving "real *malades*." In this section, I consider resistance to public health at the level of national policy before pivoting to my ethnographic observations.

Calls to embrace mental health were typically buttressed by claims of the prevalence of mental health problems. The figure that "one in four" French suffered from such difficulties bolstered declarations that, as one advocate declared at a public awareness event, "We know more and more that this is a problem that concerns everyone" (Fieldnotes, 5/12/16). Yet the actual use of psychiatric epidemiology was minimal and the numbers crude. The historic under-utilization of epidemiology as a "cognitive resource in the services of 'causes' of public health" (Bergeron 2010:83) in France was exacerbated by several factors specific to the mental health field. First, the psychiatric profession in France has a long-standing "mistrust of numbers" (Henckes 2014:45) as an "instrument of a 'society of control' in a Foucaultian sense."[21] Psychiatrists feared that statistics showing a large number of people with mental troubles could be used by the authorities to push people into public psychiatric care who did not need it.[22] On the other hand, for the most severe cases at the core of public psychiatry, a government statistician explained that "there is little need for epidemiology" because "someone with schizophrenia is going to be in care" (Interview 5/6/16).

This narrow focus on individuals with identified mental illnesses rather than populations with diffused suffering was evident in the under-development of prevention. The government's 2018 plan for psychiatry endorsed initiatives like psychological screening in schools, training students in "mental health first aid," and programs to reduce workplace stress—all inspired by foreign models.[23] But funding for such programs activities in psychiatry remained "negligible" according to French budgetary documents.[24] Many psychiatrists had long argued that early

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[20] MSS, *Feuille de route.*

[21] Milon, Alain et Michel Amiel. 2017. *Rapport sur la situation de la psychiatrie de mineurs en France.* N° 494. Paris, France: Sénat: 32.

[22] This is parallel to the French government's fear that collecting racial statistics will make race "real." They are, in effect, aware of what Hacking (1995) would call the "looping effect" of classification. Thank you to Marion Fourcade for this point (and most of the other ones in this chapter, but this one specifically).

[23] See MSS, *Feuille de route.*

[24] DREES, *Les dépenses de santé en 2017:* 154.

intervention of the kind being proposed in the U.S. for people at risk for a "first break" of psychosis meant "normalization…labeling, and invalidation"[25] of people who might never really develop into full-blown *malades* anyway. The notion that France's public psychiatric system was universally accessible seemed to obviate the need for screening. The head of France's national institute for prevention told me:

> In France, psychosis is not really an issue of public health, because we know it's going to wind up being cared for whether or not we do any campaigns about it. Sure, if you're schizophrenic, it might take ten years, but you're eventually going to get diagnosed, and there's a whole system of psychiatry that's ready for you (Interview, 8/31/16).

Even a ministry official in charge of prevention observed, "Of course we want more prevention, but we know that if you do that, you're putting less in care" (Interview, 8/17/16). In a system where the overall budget for mental health had been capped, prevention programs both directly siphoned funds from the truly mentally ill and risked flooding the *secteurs* with troubled but not truly sick individuals. If in a rationalized system an "ounce of prevention" might be worth a "pound of cure," in France the two weighed directly against one another.

Public information and de-stigmatization campaigns constitute a third tool of public health. At the time of my fieldwork, one advocacy association was making appearances at events with a series of posters that spoke of "myths and facts" about mental illnesses, stating that "mental illness is an illness like any other, except one that you don't see" (Fieldnotes, 3/22/16). Another ran a campaign with posters showing doctors, sports players, and businesspeople with the tagline, "One of these four has a psychic handicap. So what?" (see Figure 1.3). The 2005 mental health plan mandated the institute for prevention to carry out a public information campaign on "Depression: Understand More to Overcome It." Its materials carefully emphasized that sadness and suffering only became depression when it marked a "true rupture with normal functioning" as a result of "endogenous factors" (qtd. in Briffault, Morvan, and Du Roscoät 2010:6). Despite respecting this division, though, the campaign still provoked a "frontal attack from psychoanalysts who thought the institute was playing as a pawn of the pharmaceutical laboratories" (Interview, 3/12/16). Since then, noted one official, "mental health has not exactly been a priority for the [prevention] institute" (Interview, 8/17/16).[26] Psychiatric professionals across the spectrum were worried about the possible consequences of these campaigns. The director of the hospital attached to the *secteur* I studied complained: "There's a de-stigmatization…people are less afraid of going to see the *psy*, and society is not really doing well….so we have an augmentation of people who come for malaise, burn-outs…And is that part of our mission? If we accept this surge, what will happen to our schizophrenics?" (Interview, 7/1/16).

These struggles played out at ground level in the "local councils of mental health" that brought together *secteur* professionals with municipal elected officials. The latter managed the spaces where mental health outreach could take place (like community centers or programs for adolescents), the public housing where many of the mentally ill lived, and the social benefits off of which many survived. For the elected officials with whom I spoke, the local councils were a lever to get psychiatry to intervene in a range of behaviors they saw as increasingly problematic: adolescent drug use, hoarding in public housing, and Islamic radicalization (Interview, 8/13/16, 8/12/16).

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[25] Demay, *Une voie française.*

[26] The evaluation of the 2005 plan stated that anti-stigmatization campaigns are "not the object of consensus: while some associations demand a recognition of all mood troubles as a maladie, many professionals are worried about a medicalization of social problems. The state has decided not to pursue them [further public awareness campaigns]." CDC,. *L'organisation des soins psychiatriques*: 15.

Figure 1.3: Posters for a public awareness campaign, reading "One of these people is psychically handicapped… so what?"

I attended a series of local council meeting in an *arrondisement* of Paris. Beforehand, the coordinator told me, "I went to see the *secteur* psychiatrist, and they said, 'I don't want to come, because I know what's going to happen: the mayor is going to come with a list of people from public housing that they want me to deal with. I have enough clients'" (Interview, 4/12/16). The psychiatrist from the *secteur* came anyway, but spent the meeting explaining to public housing landlords "how to identify what kind of issues are not psychiatric" (Fieldnotes, 4/14/16). At another meeting, the group discussed creating a "network for dealing with complex cases." The team from psychiatry noted, "The cases that get presented—we need a prior triage to limit the number of cases that get sent to us" (Fieldnotes, 7/8/16). The group then worked on a form that would allow landlords or mayors to flag a case for the *secteur*'s attention:

> *Secteur Psychiatrist:* This form asks, 'the aspects of the person seem of what nature?' Only a doctor can determine this!
> *Secteur Nurse:* Seems like people will say 'psychic troubles' with no idea what that means…
> *Local Council Coordinator:* Well, we can just put the facts; 'threatened the neighbors, put things out the window…'
> *Secteur Nurse:* Those are just behavioral troubles!
> *Secteur Psychiatrist:* If you say 'puts self in danger' we could be obligated to intervene even if it's not psychiatric.
> *Secteur Nurse:* Yeah, I mean, if someone is in danger, call the fire department (Fieldnotes, 7/8/16).

Because psychiatrists had no obligation to attend the meetings, and the cities nonetheless needed them (particularly to involuntary hospitalize people who were particularly disruptive in public) the *secteur* was ultimately successful in resisting a formal obligation to take on such cases.

In general, even for people who did make it to an intake, the *secteur* was skeptical of those for whom a referral came from a third party who was not a doctor (see Table 1.3). For example, in a context of a national state of emergency and emphasis on security, the *secteurs* faced more and more patients who were referred by the judicial system for an "obligation for care" (see Marques, Saetta, and Tartour 2016). But in a mentality of rationing based on a normative medicalization that presumed the *secteur* existed to treat illness, the nurses told me, "It's true that when we see 'obligation for care' we are going to say right away that it's a person who doesn't want care, the interview is going to last five minutes and they just want a paper to show the judge" (Interview, 7/15/16). This perception was put into action when such patients were presented at Friday meetings:

> *Nurse:* Male, 22. Coming in the context of an obligation for care after driving a car under the influence of drugs and alcohol.
>
> *Head Psychiatrist:* So why didn't this go to an addiction doctor?
>
> *Nurse:* To be clear, he has no demand here. He's coming to because he has to.
>
> *Head Psychiatrist:* It doesn't sound like this is even pathological.

The team decided to assign the individual to an intern (trainee doctor) who would sign the paper and not give a second appointment (Fieldnotes, 2/25/16). Indeed, the *secteur* team frequently rejected the notion of comorbidity ubiquitous in the U.S.: "There are people who are more addicts than *malades,* I know that's a less clear distinction in the U.S., but here, a pure addict is going to addictology, not psychiatry. There are psychotics who consume [drugs], but people who arrive addiction through life events, personality problems… They're going elsewhere" (Interview, 7/26/16).

This expectation of both a "demand" and a classically psychiatric pathology provided a broader screening tool. It allowed the CMP to avoid responsibility for patients it didn't want by sifting out that these patients didn't want the CMP:

> *Nurse:* Female, 21. Sent to the CMP by ER for anorexia, evolving since 2015 and depression since adolescence. Hospitalization in November 2012…Currently obsessed with counting calories, BMI 14.2.[27] Stated that she 'doesn't want treatment because she will lose control' and 'does not want to think she's doing well only because treatment.'
>
> *Head Nurse:* This is someone who was send to the day hospital after hospitalization, and she didn't stick with it. Then we sent her to *liberal* and she never followed through.
>
> *Psychiatrist:* This is going to be totally unmanageable. She doesn't want anything, totally ambivalent…
>
> *Nurse:* She is motivated for help with her eating, but nothing else.
>
> *Psychiatrist:* I guess we have to take her because she was sent by the ER. But she's never really going to be cared for here.

The discussion ended with her being given an appointment 51 days in the future, to which the team assumed she would not come (Fieldnotes, 4/15/16) (see, also Gallucci, Swartz, and Hackerman 2005). For local officials, this lack of reactivity was maddening: "we have a system that is completely based on demand. They say 'we don't want to intervene in peoples' lives, control them' but the CMPs have gone too far, insisting that people need to have a clear demand to be cared for. I think that's a bit ambitious for humanity" (Interview, 8/12/16).

The construction of the object of public psychiatry as a bounded group of "real *malades*" rested on a series of shared understandings that derived from the institutional structure of the mental health system. First, the universalism of France's public psychiatric system (above and beyond that of the broader health system) justified a discourse that all the people who truly needed care were receiving it or would eventually; with the under-development of epidemiology, the evidence that this was not the case effectively did not exist. Second, French psychiatrists believed that the "need" for care was not an abstract, objective entity, but one that was in part determined by

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[27] Body Mass Index is a notoriously problematic measure but 14.2 is well below the normal range of 18.5-24.9.

their willingness to offer of care and their efforts undertaken to promote it (see, also, Fassin and Rechtman 2009:146). Responding to third party demands for care would not just increase their workload, it would expand the boundaries of psychiatric jurisdiction in ways that would detract from the people they thought actually needed treatment. Third, because the financing of France's mental health system was not modulated based on the number of people receiving care or their specific pathologies, new patients perceived as having primarily behavioral problems or dysfunctional personalities sapped funds from a common pool. The result was a widespread critique of "santé-mentalism" (a play on the word "sentimentalism") as a move that threatened to, as a major psychiatric professional organization put it, "displace the center of gravity of psychiatry and the orientation of its resources, its medical legitimacy, to a vague social register with no limits."[28] Rather than a knee-jerk resistance to rationalization, French psychiatrists were actively protecting a particular construction of both the mentally ill and psychiatric treatment that separated them from both the social and regular medical system. In such a context, the logic of rationing provided a clear set of practices for how to respond to budgetary constriction, government pressure, and widening social demands.

Allocating: Rushing Care to 'Real Malades' in the CMP

If the *secteur* was required to serve all the people with "*maladies mentales*" in a given area, it is perhaps unsurprising that Friday meetings centered on parsing out what a "*maladie mentale*" actually was. This should not be confused with saying that decision-making was actually based on diagnosis. Even if they were abstractly aware of the national-level polemics over the American Diagnostic and Statistics Manual and concretely aware that they were eventually expected to put a diagnosis in the patient's file, diagnosis played little role in orientation in a *secteur*. As one nurse put it, "I write down the symptomology—they're sad, they're crying, they're suicidal—and so we try to orient towards the idea of what the patient suffers from, but it's not a diagnosis" (Interview, 7/15/16). Rather, as suggested above, the team at the CMP reasoned in terms of broad typologies that provided a clear hierarchy for rationing based on the degree to which a problem and its solution was properly "medical." As I show in this section, this meant rushing care towards those they deemed "real *malades*."

The prototype of the *secteur* patient was someone with psychosis, which was usually coupled with social precarity. The following was a virtual archetype:

> *Nurse:* Man, 72 years old. Addressed by [inpatient unit]. Patient is afflicted by a chronic psychosis, single without children, lives alone. Hospitalized at the demand of the prefecture[29] for delirious decompensation (persecution with a sexual theme) and hallucinations (with syndrome of mental automism). Addressed by the IPPP [Police Infirmary]. While delirious, he left his domicile to hide in a hotel to escape voices, and when he perceived that this would not change the situation, broke into a neighbor's room and the employees called the police. The HAV [audio-visual hallucinations] have disappeared under Risperdal, but he remains attached to his delirium. Conservation of appetite and sleep. Says that he is recovering his autonomy and his faculties little by little. Partial critique of his troubles, good contact, correct clothing, coherent statements, adapted response (Fieldnotes, 3/18/16).

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[28] CME-UNAFAM-FNAPSY. October 31, 2014. "Communiqué sur article 13." *Obtained through personal communication.*

[29] This modality of hospitalizations, "*soins psychiatrique sur décision d'un représentant de l'État*" ("Psychiatric Care by Decision of a Representative of the State" is discussed in more detail in Chapter 4. It allows a person to be hospitalized when they pose an "imminent risk for the security of persons" or present "grave troubles for the public order."

The case provoked no debate. The head doctor instructed the secretary to give the patient a rapid meeting with the same doctor who had served him on inpatient, dispatched the social workers to confirm the stability of his housing, and tasked the nurses with making sure he came in regularly to receive an anti-psychotic injection.

For better or for worse, forty years after France began "de-institutionalization" in earnest, the privileged and fastest way into the CMP's active file was through a hospitalization, either in this *secteur* or another. The CMP could actually directly hospitalize patients, since the *secteur* also managed about 50 beds in a nearby hospital. This integration of the CMP into the circuit of hospitalization was starkly different from the outpatient clinic in the U.S., where repeated hospitalizations were a *criterion* for high levels of care but not a direct route into it *per se*. Indeed, hospitalization was often the go-to response when the CMP sensed a whiff that someone was psychotic and therefore, by definition, a real *malade*.

> *Nurse*: Female, 34 years old. Addressed by [private psychiatrist] who follows her for addiction to alcohol and medication. Eight months pregnant with a girl. Sexual and psychological mistreatment during childhood at the hands of her father. Has a twin sister. Now declaring images of violence towards her daughter. Stopped eating for 15 days to kill her. Currently only eats yogurt. Wanted the pregnancy and married since May. Sleeps little. Cold affect. Sentiment of depersonalization. Okay for a [psychiatric] following. Rapid rendezvous requested (Fieldnotes, 3/25/16).

After the presentation, there was a long silence, followed by a sigh from the nurse. Then:

> *Head Nurse:* She needs to be seen by [head psychiatrist], like, yesterday.
>
> *Psychiatrist:* We should plan a hospitalization, we're talking about infanticide here.
>
> *Head Nurse:* Yes, this is an emergency. We'll check on a bed.
>
> *Secretary:* [Head psychiatrist] has an opening next week.
>
> *Psychiatrist:* You'll have to take someone out of her schedule, get her in faster.
>
> *Psychologist:* This is ridiculous, why hasn't she been sent here before?
>
> *Psychiatrist:* [To presenting nurse] Something like this needs to be brought up first in our meetings!
>
> *Nurse:* If you look at what I wrote, it's not so so urgent… There's nothing about suicide, no history of attempts…
>
> *Psychiatrist:* No way. She's having deliria about killing her child.
>
> *Head Nurse:* This is going to take two or three months to stabilize. If she gives birth in the hospital, that's just how it is.

The team proposed a hospitalization to the woman, but she didn't show up. The head nurse again lamented that it was "ridiculous" the private psychiatrist waited so long to send them the patient. The next week, the CMP team went to her house in order to hospitalize her involuntarily. When, a few weeks later, the head nurse announced she had given birth in the hospital and "mother and daughter were doing well," the pride was palpable.

If every *secteur* I talked to presented their central responsibility in terms of treating psychoses (specified, at times, as schizophrenia or bipolar disorder), cases like these revealed the particular proclivities of the *secteur* I studied. The head psychiatrist had a special interest in mother-daughter relations, an acute concern for the risks psychotic people might pose for their families, and a fascination with elaborate delusions. Other cases provoked little enthusiasm:

> *Nurse*: Male, 28. Hospitalized via the ER for psychotic delirium. *Sans domicile fixe* [homeless]. Has been eating from a dumpster. Heavy marijuana use. Family unknown. Rapid rendezvous at CMP requested (Fieldnotes, 5/13/16).

Team members neither seemed excited about homeless cases nor questioned that they belonged in the public *secteur*. In fact, the rules for real *malades* were different from those to which they subjected other people flagged for care at the CMP (discussed in the next section). For those seen as having only "psychic troubles," for example, written proof of address, which by definition a homeless *malade* could not provide, was the first thing that a secretary asked for prior to giving an intake appointment (Fieldnotes, 5/6/16). Moreover, real *malades* did not need to articulate a demand for care and rarely came into the *secteur* on their own. They were typically either transferred in from another *secteur,* came through the emergency room, or were referred by a private psychiatrist who saw a combination of severity, chronicity, and precarity that extended beyond their ken (see Figure 1.3). These referrals were not perceived as unwanted burden-shifting, but a recognition of the *secteur's* unique competencies.

In his ethnography of a French general hospital, Juven (2018) describes how payment by the act led clinicians to focus on those whose cost of treatment was "standard" for their diagnostic group and to push away those sick who were "problematic as a result of the cost of their care." Under a global budget, though, the *secteur* did the opposite, pouring its time, personnel, and limited spots in day hospitals or therapeutic apartments to those perceived as best incarnating the figure of the real *malade*. Explained one psychiatrist:

> You need to understand—the *secteur* is made to take care of all the pathologies of a given territory, and that means the heaviest pathologies. These are maladies that are durable, chronic. I see a lot of patients I've known for 35 years. The care is repeated and repetitive, because the treatments aren't that effective. These are people who are not capable of having a project to go anywhere else, and so we're obligated to keep them, re-hospitalize them from time to time (Interview, 5/17/16).

The ethos among *secteur* psychiatrists, which one health consultant observed with annoyance, was that "We never put 'end' in a dossier, it's open for life" (Interview, 5/10/16). Ironically, because the goal of care (reduction of symptoms) and its means (medication) were both medical, and the latter was likely to be somewhat ineffective in achieving the former, care for real *malades* was impossible to reduce or rationalize.

In truth, the discourse of "care for life" ignored how even real *malades* did fall of the CMP radar. Around 10% of patients presented on Friday meetings were flagged as "*reprises de suivi*" [resumption of following]. Their dossiers had never been closed, but they had been gone for long enough that they needed to be re-assigned:

> *Nurse:* Male, 41. Consults himself for anxiety. Was followed by the CMP from 2010 to 2015. First hospitalization was for catatonia [an often-fatal manifestation of schizophrenia]. Stopped care in agreement with Dr. [X]. In interview: difficult contact, dis-trusting, coherent discourse, no thought troubles, loss of *élan vital* [life force], medium mood, no suicidal ideas, anxiety tied to fear of a relapse as in 2010. Okay to restart treatment. Upcoming meeting with Dr. [X] (Fieldnotes, 3/11/16).

Unlike in the U.S., the *secteur* had few formalized procedures for dialing down or up care. The following example, in which another *secteur* came to present a patient who had moved and thus needed a new *secteur* to follow him, captures the gaps in the *secteur*'s rationing mentality:

> *Other Secteur Psychiatrist*: This is a 57-year-old patient with a history of hospitalizations and defenestration. He first appeared in the ER in 2006, declaring that the voices were telling him to destroy his computer. He was pushed into care by his companion, who's really the one driving this. In 2007, he returned to the hospital through SPDRE [psychiatric care at the demand of the state] because he was caught being disruptive at the *Arc de Triomphe*. We placed him on 10 milligrams of Risperdal. If you look at his records, we do see that he gets better with treatment, with less delirium, but absolutely never a real critique of his actions.
>
> *Head Nurse:* How long did you hold him [in the hospital]?
>
> *Other Secteur Psychiatrist:* Two months. Not that long.

> *Head Nurse:* Then what?
>
> *Other Secteur Psychiatrist*: That's the mysterious part. We had a complete *perte de vue* [loss of sight]. And then in 2013, he jumped out a window. He says that no psychiatrist came to see him in the hospital, but when he was in rehabilitation, a psychologist [not from the *secteur*] evaluated him and writes that there was no sign of delirium. Then in 2015, his companion was reporting that he was again going towards the window, so we hospitalized him again.

The CMP team pressed to learn more about his social situation. When the head psychiatrist heard that he had two children at home, she declared:

> *Head Psychiatrist:* We need to do a visit to his domicile and know what the situation is. We can propose a meeting, but we also need to go *chez lui*. This worries me.
>
> *Other Secteur Psychiatrist:* We think that he is stable now…
>
> *Head Psychiatrist:* I don't want him to put the little one out the window! A little child, a man like this, that sends some alerts.

When the other *secteur* psychiatrist left, one of the CMP doctors commented:

> *Psychiatrist:* I can't believe it, a psychotic like this, left alone for years…
>
> *Head Nurse:* And why did no one go see him when he was hospitalized [in a general hospital from injuries from his suicide attempt]? (Fieldnotes, 2/19/16).

In crises, real *malades* would receive a huge suite of services, from home visits to hospitalizations to help in housing, from a range of professionals, including social workers, psychiatrists, psychologists, and nurses. Once stabilized, they would almost automatically receive the same level of care: a monthly meeting with a psychiatrist and some support from nurses in medication adherence. This care was intensive enough to keep most psychotics in the community and limited enough that the *secteur* could deliver it to almost their entire psychotic caseload and still keep enough in reserve for new crises. People then floated in and out. Their files never closed, but the *secteur* rarely went to seek them out, instead assuming that they would eventually reappear.

Exits and Exclusions: Dropping and Pushing Out

Which raises the question: if the *secteur* was obligated to say "yes" over many years to some patients, to whom was it saying "no"? The CMP I studied was located on the bottom floor of a non-descript apartment building; only a small sign next to the buzzer announced its presence. But laying low and avoiding third-party referrals did not protect it from the barrage of new demands for care sweeping the *secteurs*. Even if their one-way accretion over time made them a central part of the CMP caseload, people with psychosis constituted less than 20% of new cases presented at Friday meetings. Instead, the leading characterizations were of "anxiety" and "depression," or the combination of the two ("anxio-depression syndrome"), which were the primary problem in nearly 50% of cases. They were followed by instances of insomnia, eating disorders, suicidality (without an explicit characterization of it following from depression), and trauma (see Table 1.2).[30] When nurses presented the cases, they noted that these people came only rarely for "*soins*" but rather "support" "aid" "to talk" or "advice" (Table 1.3). For example:

> *Nurse:* Woman, 44. Referral: herself. She demands support. Says that her partner has quit her home, leaving her with four children. Now lodged by a pair of friends. The children are struggling to understand what happened and she is having difficulty with respect to this reaction. Unemployed for 14 years. No prior treatment. Anxiety, trouble sleeping, crying, no

---

[30] These findings are consistent with other data on the population served by the *secteurs*. One study found that 19% of *secteur* patients had schizophrenia, 4% bipolar, 21% depression, and 56% "neuroses," a psychoanalytic category nominally in official disuse (Sauleau, Lefèvre, and Handschumacher 2014:506)

Table 1.3: Reasons for Consultation

		Clinic (California)	**CMP (Paris)**
Referral Source	*Social Services*	18%	4%
	Hospital	18%	14%
	Self	14%	34%
	Other Public MH	14%	7%
	Family / Friend	11%	5%
	*Private MH / PC**	7%	16%
	Courts / Jail	5%	3%
	Crisis Services	5%	17%
Stated Demand	*Administrative*+	36%	7%
	Medical Treatment	37%	13%
	Psychological Support♦	7%	32%
	Resistant / Opposed	10%	29%
	None/Unclear	7%	8%

* Such as help filling in paperwork for disability, housing, or the judicial system.

+ For France, this would be "liberal psychiatrist / psychologist," "generalist doctor," a doctor of another specialty, or a work doctor (*médecin de travail*). In the U.S., these were rarely solo practitioners but primary care or specialty mental health clinics for people on Medicaid.

♦ In France, characterized as demands for "support", "advice", "talking", or "psychotherapy."

> *idées noires* [dark ideas]. States that she 'wants help passing this difficult moment' (Fieldnotes, 2/25/16).

Cases like these were emblematic of how the *secteur* was increasingly subject to the "overflowing of the social" (Baudot 2015:11) and the never-ending "enlargement of demands tied to psychic suffering" (Ehrenberg 2005:29) facing the rest of the French state.

Because the response to real *malades* often seemed obvious, the conflicts and tensions of the Friday meetings centered on what to do with these people. Surveys find that 60% of French people using specialized psychiatric services characterize themselves as having a "psychic trouble,"[31] which they define in the same way as professionals: a condition external to the person, which clearly marks them as separate from a true *malade* with an inner pathology. A consultant in the national agency for health performance (ANAP) explained how a "rationalized" system of levels of care and triage could respond to such cases:

> We think the issue is not that there are too many people but one of organization. If the *secteur* tries to take everyone *n'importe comment* [any which way], it will be overwhelmed…Rather, there should be a specialized team—not just a nurse—focused on orientation and reception. You really evaluate the needs of the person…Then there's a gradation of care, you go either towards a psychiatrist, or a psychologist, or a specialist nurse, or back to your generalist doctor (Interview, 5/10/16).

In the *secteur* I studied, though, it was difficult to gradate care because all levels of care were oriented primarily towards the real *malades*. Even the psychologists, mostly trained in psychoanalysis, wanted to analyze people with psychosis. On the other hand, all care at the CMP had ultimately to be

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[31] Chapireau, François. 2012. *Les recours aux soins spécialisés en santé mentale*. N° 533. Paris, France: Direction de la recherche, des études, de l'évaluation et des statistiques.

Table 1.4: Decisions and Reasoning

Clinic (California)		***CMP (Paris)***	
Level of Care Assigned			
Full-Service Partnership	12%	*Hospitalization*	4%
Intensive Case Management	40%	*Secteur MD*	61%
Commitment to Community Living	6%	*Intern*	15%
Extended Therapy	3%	*Private Practitioner*	12%
Defer	6%	*Defer*	1%
Refer Out	6%	*Other**	7%
Close	27%		
Reason for a Higher Level of Care			
High Service Use	23%	*"Isolated", "Fragile", or "Vulnerable"*	27%
Homelessness / Risk to Housing	20%	*Risk to Family*	18%
High Case Management Needs	20%	*Lack of Resources*	13%
Severity / Decompensation	15%	*Uncertainty About Situation*	13%
Danger to Self / Suicidality	8%	*Severity*	11%
Danger to Others / Risk	8%	*Prior Secteur Treatment*	5%
Criminal Justice Involvement	7%	*Risk to Self*	5%
Low Engagement / No Demand	7%		
Vulnerability	5%		
Co-Morbidities	5%		
Reasons for a Lower Level of Care or Referral Out			
Stable Housing / Housed	26%	*No Demand*	19%
Low Service Use	18%	*Psychological / Reactional*	18%
Stability	14%	*Not Severe*	16%
Low Engagement	12%	*Not Psychiatric*	13%
High Engagement	9%	*Secteur Inappropriate*	8%
Treated Elsewhere	5%	*Can Pay Private Doctor*	8%
Low Danger/ Risk	5%	*Not Urgent*	8%
Not Mental Illness	3%	*Administrative*+	4%
Reasons for Closure			
Disappeared	33%	N/A	N/A
Refuses Services	30%		
Moved	17%		
Receiving Services Elsewhere	13%		
Institutionalized / Incarcerated	6%		

This table codes instances where a reason for a decision was explicitly articulated. In many cases, especially in France, no reason was explicitly stated and decisions were made without discussion. Although the reasoning was usually clear, I have not inferred motivations in constructing this table.

* Such as an addiction specialist.

+ Such as not having an address in the *secteur* (France) or having a chart open with another provider (CA).

medicalized: the head of the *secteur* had ruled that, as a medical establishment, every person whose problem was at least plausible "*psy*"—that is to say, either a trouble or an illness, and not simply a behavioral or personality dysfunction—would see a doctor.[32] The head of the CMP described the situation, "We've been told to serve everyone, but that's impossible. So we do the triage ourselves, because the core of our work, it's mental illness" (Interview, 6/28/16).

One of the few clear modes of recourse for dealing with psychic troubles was to refer patients out to private (or "liberal") psychiatrists, which the *secteur* did in response to 12% of demands (Table 1.4). This practice was not formally regulated and had no official criteria, but the ministry had validated this technique of rationing as a legitimate way for the *secteur* to "disgorge itself" in order to "center the CMPs' means on the most severe cases" (Interview, 7/11/16). While some public psychiatrists moonlighted as psychoanalysts in private *cabinets,* the symbolic distance between the public and private wings of the profession was enormous. As one psychiatric professor declared:

> There aren't enough schizophrenics, real *deprimés* [depressed people] for all the psychiatrists to have work, so what do they do? They go to Boulevard Sainte Germain and take a client that isn't really sick, but the grand bourgeois [who is] a little stressed, or women who are bored, or their complicated children, and these psychiatrists are trained at the expense of society, and we pay them to care for people who have a little blues of the soul (Interview, 5/11/16).

The CMP used liberal psychiatry to quickly offload those they could. Before even reading the intake summary, one nurse stated:

> *Nurse:* Should I start with his salary?
>
> *Psychiatrist:* Sure.
>
> *Nurse:* He makes 3000 euros [a month] and works at MGEN [a major insurance company].
>
> *Psychiatrist:* Do we even have to discuss this?
>
> *Nurse:* Appears to have an anxio-depression, with no manic elements. Lost his mother in June and is having troubles with his two sisters subsequently. Describes troubles with stress, difficulty sleeping, and a deterioration of his marital relationship.

At this point, I observed that the head nurse and psychiatrist were already talking about something on the side. His income, in this case, was overriding. When the nurse commented, "He talks about some 'mystical elements' but other than that seemed pretty normal" the psychiatrist looked up: "Liberal" (Fieldnotes, 4/19/16).

The rationing-through-typologies approach of the *secteur* assumed a coupling of high-income and low-severity. Psychiatrists often acted as if that association existed even when it plainly didn't, as in the case of one woman who came to the *secteur* after a stint in a private hospital:

> *Nurse:* Female, 45. Patient leaving a hospitalization at [Private Hospital] where she was hospitalized from [date – total length of hospitalization: 58 days] voluntarily for depressive symptoms with suicidal ideation (images of defenestration) in the context of professional difficulties…Problems in adaptation since her arrival in France. Socially isolated. Quitting work. Suicidal ideation still present, although rarer, and no intention of carrying it out. No real previous treatment: had consultation at [hospital to which the *secteur* was attached] but decided no treatment was necessary (Fieldnotes, 4/19/16).

Despite the fact that the *secteur* had already (incorrectly) deemed the woman as not needing treatment, and that she now was being sent to them by the private sector on the basis of being too

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[32] In contrast to California, the social workers would not help patients with paperwork for housing or disability income unless they were also seeing their doctor.

severe, the head psychiatrist rapidly declared, "Liberal." Some outside actors viewed this practice with frustration: "The CMPs say that they only take on the people with the 'most serious problems.' That means that people who are going through a psycho-social difficulty, a 'trouble' as it's described in the manuals, but who are seriously at risk… they're not treated" (Interview, 3/24/16).

The logic of rationing actually required some substantial leaps of logic, like that "psychic troubles" were typically the "blues of the soul" of the Parisian bourgeoisie. If few of the *secteurs* patients lived in extreme poverty, many were on the edge. Of the patients for whom some reference to their employment was made in the nurse's presentation, a quarter were unemployed, a quarter were students, and most of the rest worked in low-level service jobs. One of the social workers in the *secteur* told me:

> *Social Worker*: We are seeing more psycho-social troubles than psychiatric ones. Sure, we have the cases that are a bit brutal: the guy who's 18, smokes a bit of pot, completely falls apart and thinks he's a bird, and that happens whether you're rich or poor, black or white, ugly or beautiful. But we have more people for whom it's like, 'Okay, yeah, with that life, who wouldn't go crazy?'
>
> *Interviewer:* And is that a problem for psychiatry to deal with?
>
> *Social Worker:* Maybe it's not psychiatry, but it develops over time, and it needs treatment.
>
> *Interviewer:* But treatment in the *secteur*?
>
> *Social Worker*: I mean, there's nothing else. It's still suffering (Interview, 4/12/16).

When doctors attempted to push this misery onto the private *secteur,* they often received pushback for the nurses who were more fully away of their social situation:

> *Nurse 1:* Madame is 45 years old. Came to us after being referred by the ER for anxiety-depression. Lives in an 18 square meter apartment. Never married, no children. Father died of Alzheimer's. Worked as a secretary, but stopped in 2013. Traumatizing relationship with boyfriend. States she is 'disgusted with herself.' Four months of suicidal ideation, without plan: 'I want to leave, but I don't want to go.' Tried multiple anti-depressants from generalist doctor, but no effect. Somewhat flirty. I'm suggesting Doctor [X]
>
> *Psychiatrist:* Where does she work?
>
> *Nurse 1:* She *was* a secretary.
>
> *Psychiatrist:* Great. She can go to liberal.
>
> *Nurse 2:* She can't advance eighty euros, even if she's reimbursed…
>
> *Head Psychiatrist:* [Liberal psychiatrist] loves flirty patients!
>
> *Nurse 1:* She can't pay! (Fieldnotes, 4/19/16).

That nurse later told me, exasperated, "There are times when we really don't agree with the private sector orientations. We're the one who have to tell them, and they don't understand" (Interview, 7/15/16). One patient was presented in three subsequent weeks, each time having been sent to a psychiatrist who was not taking new patients. The nurse elaborated, "Some manage to get an appointment [with a private doctor]…Others feel rejected and… well, we don't follow up."

People with "depression" occasionally sat at a borderline between "maladies" and "troubles." Here, the logic of rationing rested on a different heuristic that divided between depression that was "endogenous," which made it a medical disease, and sadness that was "reactional" to external circumstances. These questions of disease causality have been effaced in the American DSM (Horwitz and Wakefield 2007) but were clearly part of the cognitively medicalized categories French professionals used, and could provoke debate:

> *Nurse:* Male, 78. Was followed at [CMP in another *arrondisement*] for depression after the death of his wife from cancer. Describes some obsessive-compulsive behaviors subsequently, but has not been hospitalized. Little contact with his children. Some suicidal ideas. Serious somatic problems.

> *Psychiatrist:* Is this really something that belongs in a CMP?
> *Head Psychiatrist:* He's better off in liberal. Who takes the old ones?
> *Psychiatrist:* He'll manage.
> *Head Nurse:* He just needs to talk (Fieldnotes, 7/1/16).

While nurses presented psychosis as a *sui generis* illness with no apparent cause, they characterized a quarter of new patients as consulting for family troubles and a fifth as having problems with their work or social situation. Even clearly traumatic events, though, would leave the team non-plussed so long as they were external impositions and not internal pathologies:

> *Nurse:* Woman, age 43. Called this weekend to demand a *prise en charge* post-attack. Madame was in the pit at the Bataclan [where terrorists killed 90 people in November 2015]. Injured by a bullet to her shoulder; hospitalized 10 days, in a work stoppage as a home health aide subsequently.
> *Head Nurse:* She just needs time (Fieldnotes, 3/18/16).

While a lack of explanation could make a depressed person into a *malade,* a clear external origin of someone's problems could be a sign that they were only psychic troubles. For such patients, one of the only options beyond sending them to the liberal *secteur* was assigning them to the medical students who rotated through the *secteur* as part of their training. With no protocol for gradating the kinds, intensity, or length of care, the *secteur* ultimately fell back on modulating the type of doctor. It was thus an example of "rationing by dilution" in which people receive what was widely understood to be "less intensive" or "second best" (Schmidt 2004:972). They did this not because restricting care itself was moralized as a good thing (as in the U.S.), but because, with fixed budgets, the logic of rationing made it seem like there was no alternative.

Ultimately, though, most cases of psychic troubles wound up in the caseload of the *secteur*'s doctors. They knew most patients could not pay for a private consultation and the CMP could only send so many cases to the interns. And so, even in my short period of observations, I could see the average wait time for new patients creep up, except for the 10% of patients (almost always real *malades* with psychosis or—better—those suspected of it) given an emergency appointment:

> *Nurse:* Young woman of seventeen years (18 next month) coming to the CMP on the advice of a friend for anger (without reason) and to calm her, because she continues to cut her arms with scissors. Frequent conflict with her family; do not send mail to the house for a rendezvous, because she does not want her parents to find out. Humiliated and persecuted by her ex-boyfriend. Limited sleeping or eating, fearful of death, dark ideas and suicidal ideas without an immediate plan.
> *Head Psychiatrist:* Well, she should definitely be seen.
> *Secretary:* Doctor [X] has something [date in 40 days]. (Pause)
> *Nurse:* Maybe a nurse could see her…?
> *Head Psychiatrist:* Yes, we have no choice.
> *Head Nurse:* She can come back to the CMP if there's an emergency.
> *Head Psychiatrist:* I wish we knew what was behind this… (Fieldnotes, 4/15/16).

Not every "reactional" depression was mild; in fact, more and more patients with serious suicide attempts were leaving the hospital with appointments at the CMP a month in the future. Yet in assigning these diverse cases to a similar, low level of care—the occasional consultation with a doctor, and punctual meetings with nurses to fill in the gaps—the *secteur* professionals had to act as if people fit into the typologies of persons around which the logic of rationing was organized. The statistics showing that an increasing number of people were being served in the *secteurs* thus needs to be contextualized; for at least some of these cases, the *secteur* was formally saying "yes" but, in its allocation of resources, effectively saying "no."

The United States: Rationalizing for Health, Quality, and Cost

Regulating: Crafting the Managed Care Continuum in New York State

Strikingly, while in France providing care for the real *malades* seemed to obviously conflict both with cost controls and broader initiatives to improve population health, in the U.S. the logic of rationalization has long treated the "triple aim" of care, quality, and costs as mutually reinforcing. These connections were visible even from Kennedy's 1963 "Special Message to Congress" in which he announced a federal policy of de-institutionalization. He declared that mental illnesses now "waste more of our human resources and constitute more financial drain upon both the public treasury" than any other conditions. Community care, however, could restore "all but a small proportion…to useful life" as well as "save public funds" and "conserve our manpower resources."[33] Over time, dominant actors have increasingly sought to achieve this triple aim through institutional medicalization, reducing the barriers between the organization and regulation of mental health care and the rest of the medical system.

In the 1970s, while France was abandoning cost-benefit calculations of mental health care as unworkable and turning to a "global budget" to cap mental health expenses, Medicaid was already conducting "utilization reviews" of the appropriateness of the limited range of hospitalizations for it would even consider paying.[34] Meanwhile, public and private insurance pushed to limit open-ended psychotherapy in favor of the shorter and more punctual medication consultations that might be delivered by any other medical specialist (Grob and Goldman 2006:141). While states continued to also finance mental health care (particularly, inpatient care) directly through general funds, these programs, as one "primer" on mental health financing in California put it, were "never conceived of as an entitlement" (which was "unlike services to persons with developmental disabilities").[35] This difference, the presentation noted, "built rationing of services into the framework of mental health service delivery" from the start.

"Rationing" through overall limits on spending, however, does not capture the way governments have used cost-controls not just to protect the public coffers but to achieve more positive aims. New York's transition to "managed" behavioral health care, effected between 2011 and 2017, is a case in point. Even in an era where public hospitals were a main line item in state budgets, New York was an outlier, spending up to a third of its revenues to finance 90,000 beds by the 1950s (Grob 1991:161) (see Figure 0.1). New York joined other states in the '80s and '90s in tasking private managed care companies with the distribution of Medicaid funds, a process that has only accelerated post-Affordable Care Act (Figure 1.4). Like many states, though, it created a "carve out" that excluded mental health from managed care, whose exceptionalism within the universe of health policy in New York was symbolized by a stand-alone Office of Mental Health (OMH).

As time has worn on, though, many states have come to see the high *physical* health expenses of people with *mental* illnesses as signs that "fragmented systems of care with little no coordination across providers" have meant "poor health care quality and high costs"[36] (Brown and Cooksey 1989:1134). Rationalizing expenses thus meant institutional medicalization through reframing mental health as simply one constituent part of the broader health system. By 2017, only 11 states continued to exempt mental health from their broader, market-oriented attempts to control Medicaid

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[33] Kennedy, *Special Message to the Congress*.

[34] Comptroller General, *Returning the Mentally Disabled to the Community*.

[35] Ryan, Patricia. "California Mental Health Funding 101." *California Mental Health Directors Association.*

[36] Soper, Michelle. 2016. *Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators*. Hamilton, NJ: Center for Health Care Strategies.

Figure 1.4: The Spread of Managed Care in Medicaid

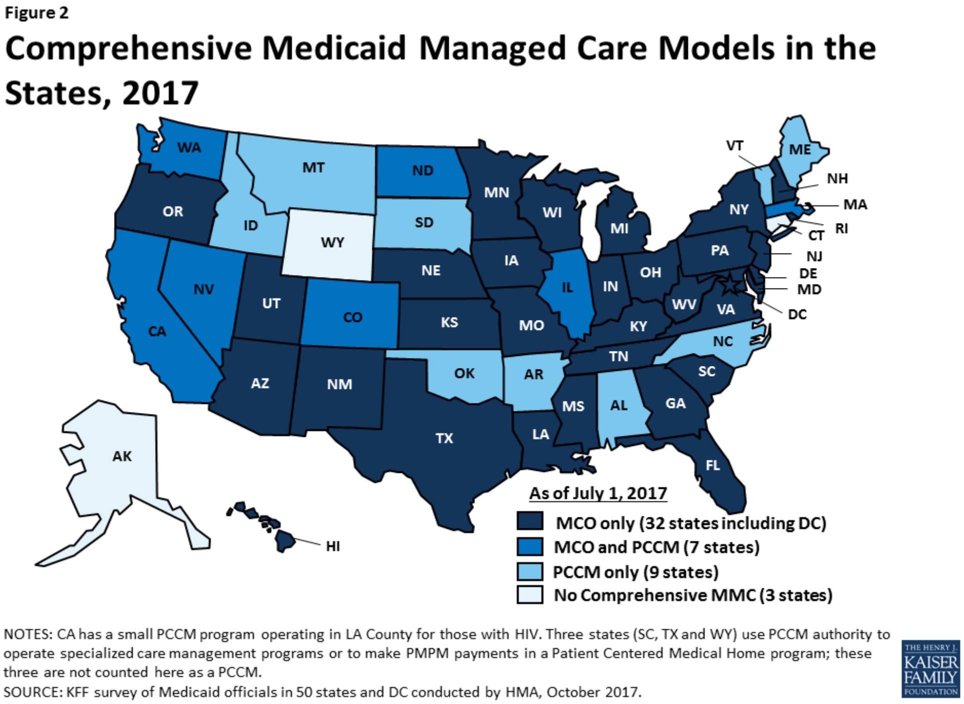

Figure 2

Comprehensive Medicaid Managed Care Models in the States, 2017

As of July 1, 2017

- ■ MCO only (32 states including DC)
- ■ MCO and PCCM (7 states)
- ■ PCCM only (9 states)
- ☐ No Comprehensive MMC (3 states)

NOTES: CA has a small PCCM program operating in LA County for those with HIV. Three states (SC, TX and WY) use PCCM authority to operate specialized care management programs or to make PMPM payments in a Patient Centered Medical Home program; these three are not counted here as a PCCM.
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2017.

Source: KFF, *Medicaid Moving Ahead in Uncertain Times.*

expenses.[37] These shifts have had enormous impacts on the kinds and quantities of care delivered, given that Medicaid is the single largest payer for mental health care in the U.S. (Figure 0.11).[38] As one trade publication observed, approvingly:

> Managed care sure bent the cost curve, all right…From 1986 to 2005…the share of health care spending dedicated to mental health and substance abuse treatment dropped from 9.3 to 7.3 percent. This period coincided with the advent [of]…managed behavioral health care organizations (MBHOs), which effectively popped the tires on the nearly unchecked mental health care inflation that had characterized the years following deinstitutionalization (see, also, Figure 1.1).[39]

That comparatively shrinking outlays for mental health care were a good thing was, at least for these authors, unquestioned. It evokes the moralization of scarcity evoked by Livne (2014) for hospice care, except that the severely mentally ill were not dying, just racking up expenses.

In 2011, Governor Cuomo announced a plan to "carve in" in mental health services into the state's broader Medicaid Managed Care system, a plan which would be carried through by the Department of Health, *not* OMH. New York's "Fee For Service" Medicaid model, in which providers were paid for the acts that they performed (already a more "rationalized" payment system than the global budget in France) without any intensive review of their effects, was as one

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[37] Kaiser Family Foundation. 2017. *Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018*. Menlo Park, CA.

[38] SAMHSA, *Projections of National Expenditures.*

[39] Dalzell, Michael. 2012. "Mental Health: Under ACA, Is It Better To Carve In or to Carve Out?" *Managed Care Magazine*. Retrieved March 20, 2019 (https://www.managedcaremag.com/archives/2012/12/mental-health-under-aca-it-better-carve-or-carve-out).

presentation to the state's Medicaid redesign working group put it, "irrational."[40] A psychiatrist at a major research institute explained that the old model was "inherently problematic because it's structured around profits, not outcomes. We are spending a lot of money in New York on psychiatric care" but without commensurate gains in "health, health care, and efficiency" (Interview, 12/28/16). Of course, under a new managed care model, qualified managed care organizations would also seek profits. But their profits would come out of those previously earned by private care providers, through "monitor[ing] behavioral health inpatient length of stay," "reduc[ing] unnecessary…inpatient hospital days," "reduc[ing]…readmission rates," "improv[ing] rates of engagement in outpatient treatment," "profil[ing] provider performance," and "test[ing] metrics of systems performance."[41] As one psychiatrist who had just taken a job at a managed care company joked, "I remember when the Director of OMH was talking about how managed care is 'going to reduce homelessness, [criminal justice] recidivism, re-admission' and I thought 'and bring about world peace!' The expectations are very daunting" (Interview, 1/19/17).

The state's aspirations for how running behavioral-health Medicaid dollars through managed care companies would improve "health" were indeed ambitious. The 2013 state plan set a goal of reducing the proportion of New Yorkers "reporting 14 or more days with poor mental health in the last month" by 10% by December 31, 2017[42]—a target that relied on population-level tracking with little equivalent in France. How managed care's impacts should be evaluated in terms of "health care" was more contentious. The state admitted that, for mental illnesses, "There are no widely accepted measures of key recovery domains."[43] Instead, in an example of normative de-medicalization, the redesign largely collapsed goals in "care" or "quality" into those geared towards "efficiency." From the earliest meetings, the state Department of Health called attention to how a small number of people with co-morbid psychiatric and physical health conditions drove a huge proportion of Medicaid spending.[44] These users would be identified through an algorithm and enrolled in specialized "Health and Recovery Plans" (HARPs) run by managed care companies that would provide integrated services. In the abstract, HARPs were to be "person-centered," "recovery-oriented," "data-driven," "evidence-based," "peer supported," and "inclusive."[45] Yet the actual basis of enrollment in HARPs was that someone had multiple claims for high-intensity outpatient services, 30 days of inpatient hospitalizations, three or more hospital admissions, or a history of treatment in state hospitals or through the Department of Corrections. Their central goal—whether or not one called it "recovery"—was to reduce use along these metrics by providing less expensive in-home supports, medication management, and primary care. As one consultant reminded the

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[40] Behavioral Health Reform Work Group. May 1, 2013. "Managed Care and Behavioral Health." *Presentation to Medicaid Redesign Team.* Albany, NY.

[41] Behavioral Health Reform Work Group. 2011. *Medicaid Redesign Team: Final Recommendations.* Albany, NY: New York State Department of Health: 50.

[42] Office of Mental Health. 2013. *Statewide Comprehensive Plan, 2014-2018.* Albany, New York.

[43] Behavioral Health Reform Work Group. March 27, 2015. "Managed Care and Behavioral Health." *Presentation to Medicaid Redesign Team.* Albany, NY

[44] Department of Health. July 12, 2011. "New York State Health Home Federal Rules and Potential Models." *Presentation to Medicaid Redesign Team.* Albany, NY. The same point was made in California, where 5% of MediCal beneficiaries, most of whom having a behavioral health diagnosis, account for 51% of total expenses. Tatar, Margaret and Richard Chambers. 2019. *Medi-Cal and Behavioral Health Services.* Oakland, CA: California Health Care Foundation.

[45] Department of Health. 2015. *Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation.* Albany, NY: 17.

Medicaid Redesign Team in a power-point, "More care isn't necessarily better care. In many cases, more care is bad care."[46]

Given the huge new administrative burden and oversight of professional autonomy, the absence of any visible mobilization against the managed care transition in New York State is striking. One City Mental Health Director for a major outpatient provider told me, "In 1991, when you first started to see Medicaid Managed care, there was a lot of push back of, 'You need to leave behavioral health out.' A lot of, 'It's untested, it's unproven'" (Interview, 1/11/17). But by 2011, that mental health care would be institutionally medicalized and managed was *fait accompli*. Two psychiatrists wrote on behalf of the New York State Psychiatric Association that there was "little to no scientific evidence that…Medicaid MCOs [Managed Care Organizations] will improve…clinical outcomes or reduce costs,"[47] but there are few other traces of the organization's engagement with the policy. The Coalition for Behavioral Health Providers, a major trade group for outpatient clinics, called for preserving the independence of OMH from the Department of Health and for a temporary "freeze" of overall mental health expenses, but ultimately participated in the Medicaid redesign (Interview, 9/11/17).

Because New York has a density of psychiatric beds and length of stay substantially higher than the national average, inpatient treatment was a prime target for managed care.[48] Observed one patient advocate, approvingly, "The majority of interest in Medicaid redesign is, simply put, helping people get out of hospitals who are going too often, and not getting better, and the state is spending too much money on them" (Interview, 9/12/17). Because they were left out of the initial roll out of managed care, psychiatric hospitals became an appealing investment for health care providers through the '80s and '90s (Frank and Glied 2006:73). Even into the 2000s, many hospital psychiatrists noted how different working with private insurance and Medicaid was: "At [Public Hospital], almost none of the patients had private insurance, and Medicaid would just pay. There was no pressure to discharge them, no one calling for an update after three days" (Interview, 12/2/16). The Medicaid managed care shift in New York, however, embraced "prospective payments" that paid a higher rate for the early days of hospitalization[49] and utilization reviews that would require psychiatrists to justify keeping patients to a psychiatrist employed by the managed care company. The vision for the role of hospitalization in this new situation, an OMH director explained, was radically reduced: "We are working with clinicians to understand that someone may have active symptoms, problems with functioning…but still be discharged. The doctors have to accept that they can only help people to a certain extent, that doesn't mean they should stay in the hospital forever" (Interview, 12/16/16). Rationalization entailed redefining the goals of mental health treatment away from symptom reduction towards basic functioning.

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[46] Margolin, Ilene. July 12, 2011. "Principles and Practices of Managed Care." *Presentation to Medicaid Redesign Team*. Albany, NY.

[47] Perlman, Barry B. and Henry Harbin. n.d. "Will NYS's Transition to Medicaid Managed Care Serve Those with Serious Mental Illness Well?" *New York State Psychiatric Association*. Retrieved March 21, 2019 (https://www.nyspsych.org/index.php%3Foption%3Dcom_content%26view%3Darticle%26id%3D59:nys-s-transition-to-Medicaid-managed-care%26catid%3D20:site-content).

[48] The national median length of stay in community hospitals (i.e. excluding state hospitals) for psychiatric patients was 4.7 days in 2010. SAMHSA, *Behavioral Health United States*: 131. For New York City, it was 11 days. Department of Health and Mental Hygiene. 2016. *Adult Psychiatric Hospitalizations in New York City*. New York, NY.

[49] U.S. Department of Health and Human Services. 2002. *Report to Congress: Prospective Payment System for Inpatient Services in Psychiatric Hospitals and Exempt Units*. Rockville, MD.

Previous research highlighted how some older mental health professionals treated managed care as a moral monster to be resisted (Kirschner and Lachicotte 2001; Luhrmann 2000). By the time of my research, though, reducing length of stay had clinical support as well:

> *Clinical Director:* It used to be that our length of stay was eighteen days. Now we've got it down to twelve or fourteen, and they [managed care] won't authorize it further. So if we don't discharge people…Well, you want three days, but nobody wants to pay for it and the people [patients] want to go anyway…
>
> *Interviewer:* But if there's a psychiatrist who says, 'I don't care whether they pay, I am focused on patient care,' or they're worried about liability, what happens?
>
> *Clinical Director:* Well I'll tell you what I do. I post a length of stay, by psychiatrist, with their name. Feeling pressure is the best way to get it done. I did that and all of the sudden the two guys who were outliers suddenly saw it… The problem pretty much took care of itself (Interview, 1/7/17).

One "cornerstone" of managed care (Boyd 1998:202) added by the Medicaid redesign was doctor-to-doctor reviews. An inpatient psychiatrist explained:

> *Psychiatrist:* It's actually easier if they're uninsured. If they're insured, you get so much pressure. There are MDs who work for insurance companies and they want to know in a detailed way why someone isn't appropriate for outpatient and it's hard to make the case. I don't try too hard.
>
> *Interviewer:* Because you know you're going to lose?
>
> *Psychiatrist:* Yes, I know I'm going to lose, and their mind is made up before they even call.
>
> *Interviewer:* And how does that even get set up?
>
> *Psychiatrist:* They schedule it and give you a specific timeframe, and if you're not available in a ten-minute window, you forfeit your opportunity to argue for a longer length of stay (Interview, 11/30/16).

These pressures altered medical practices, not just discharge times. The clinical director explained that she insisted nearly all patients be put on injectable medications, which would stabilize them enough for discharge without having to work with them on accepting treatment.

What did this new layer of management and new set of requirements on providers actually amount to? In the short term, managed care did not save the state any money, because of a requirement that money from reductions in hospitals be plowed back into the development of "non-clinical" services like employment services and housing.[50] Over the 2011 to 2015 period, the number of people receiving public mental health treatment in New York State actually increased by nearly 60,000, reaching 3.9% of the adult population (higher than in France).[51] Managed care was not a system of strict rationing or budgetary austerity, but one of rationalization which, as the minutes from one Medicaid Redesign Team put it, "create[s] incentives to titrate treatment to ensure that costs are reasonable for circumstances at hand."[52] This could mean encouraging hospitals to treat more aggressively, especially with hospitalized patients, in order to more quickly move them down to a lower level of care (Interview, 1/11/17). Utilization reviews from managed care, the state suggested, could be used for outpatient care that exceeded the mean number of sessions per year for a given condition *or* for a failure to intensify outpatient care after repeated hospitalizations.[53] Achieving the "triple aim" of population health, care quality, and cost was not just about

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[50] Behavioral Health Reform Work Group, *Medicaid Redesign Team: Final Recommendations*: 8.

[51] Office of Mental Health. 2016. *Statewide Comprehensive Plan, 2016-2020*. Albany, New York: 1.

[52] Behavioral Health Reform Work Group. August 23, 2011. *Medicaid Redesign Team Minutes*. Albany, NY.

[53] DoH, *Transition of Behavioral Health Benefit into Medicaid Managed Care*: 49.

withholding care from some and giving it to others, but calibrating care strategically, rationalizing it via tools drawn from the medical system. Amidst this institutional medicalization, though, there were visible elements of normative de-medicalization, by gearing treatment towards measurable goals that decreased peoples' contact with medicine, if not diminishing their medical condition.

Constructing: Public Health for Population-Level Mental Health in New York City

Although the U.S. is often presented as under-investing in "public health" strategies, their embrace with respect to mental health has been much less hesitant than in France. As the Surgeon General wrote in 2001:

> The Nation's contemporary mental health enterprise, like the broader field of health, is rooted in a population-based public health model. The public health model is characterized by concern for the health of a population in its entirety…Public health focuses not only on traditional areas of diagnosis, treatment, and etiology, but also on epidemiologic surveillance of the health of the population at large, health promotion, disease prevention, and access to and evaluation of services.[54]

This section considers how, together, these techniques construct the object of public mental health systems as an expansive continuum encompassing those who in France would be considered as having "psychic troubles" as well as "real *malades,*" with a whole range of intermediate spaces between the two. New York City's *Thrive* initiative simultaneously built on the institutional medicalization of Medicaid managed care and the normative and cognitive de-medicalization of the care that actually got delivered.

The discursive shift from "mental illness" to "mental health" came early in the U.S. After World War II, for example, reform-minded psychiatrists sought to relabel their work from addressing "neuro-psychiatric" issues to "mental health" ones, under the assumption that the previous framing had led to neglect of people with conditions other than psychosis (Grob 1991:51). The discourse of mental health has always rested on epidemiology showing the widespread prevalence of mental illness. The federal government began collecting statistics about mental illnesses in the population in the 1840 census (Mechanic et al. 2014).[55] Claims that "mental illnesses are shockingly common" and "affect almost every American family"[56] provide rhetorical motivation for reports in the U.S. just as they do in France. But the figure that "nearly one in five Americans" suffers from mental disorders "in any year"[57] has more weight in a healthcare system where advocates and entrepreneurs for a given condition are expected to aggressively pursue scarce funds in competition with others (Best 2012).Indeed, figures on the prevalence of mental health problems nearly always appear alongside statements about the prevalence of treatment, creating a picture of "disturbingly low" use of services (Kessler et al. 2008:201).

The U.S. has shown little fear of the broadening reach of mental health institutions that gave the French pause. As President Obama waxed in opening a 2013 conference on mental health:

> Too many Americans who struggle with mental health illnesses are still suffering in silence rather than seeking help, and we need to see to it that men and women who would never

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[54] Surgeon General, *Mental Health*: 1.

[55] These figures were used most famously to argue that African Americans released from slavery had higher rates of madness than those still under bondage (K. Davis 2018).

[56] President's New Freedom Commission, *Achieving the Promise.*

[57] Surgeon General, *Mental Health.*

> hesitate to go see a doctor if they had a broken arm or came down with the flu… have that same attitude when it comes to their mental health.[58]

The urgency of statements like these often gloss over substantial variation in treatment rates, from 64.9% of people with "severe impairment" to only 28.6% of those with "mild impairment."[59] From the perspective of a mental health continuum, though, increasing treatment for the latter does not divert resources from the former, but is actually a rational way of controlling costs by preventing "mild" conditions from becoming "severe" ones. The confidence of government claims that mental health treatment can alter not just individual mental states but the health of populations is striking. One policy paper aimed at convincing states which had not expanded Medicaid under the Affordable Care Act to do so, for example, claimed that with expanded mental health treatment "there would be 371,000 fewer people experiencing symptoms of depression."[60]

New York City Mayor Bill De Blasio describes the city's "Thrive" initiative, launched in 2015, as "revolutionary."[61] It nonetheless builds on this broader understanding of mental health as a continuum which could be affected not just with medical treatment but public health initiatives far from the techniques of medicine, traditionally understood. The preface to the Thrive plan evokes the iconic "one in five" estimate, but calls it "conservative" and notes that only 40% of the mentally ill in New York City received care.[62] This sense of the ubiquity of mental health problems, one official in City Hall explained, emerged from the left-leaning administration's roll-out of a range of other social service programs: "We kept hearing from our [social service and employment] partners that mental health was a key barrier. Organizations were not meeting their benchmarks, and they were saying that was because of clients' mental health and substance abuse problems" (Interview, 12/28/16). After a decade in which spending was stable, Thrive pushed the city's budget for behavioral health care up 25% from 2015 to 2019, to $1.2 billion per year.[63] Exclaimed one service provider, "It's a good time for mental health services…In New York City, there's a lot of attention on it right now. Our CEO calls it 'Our 15 minutes of fame'" (Interview, 12/5/16).

Thrive sought to shift the center of gravity in public mental health care towards screening, prevention, de-stigmatizing, and early intervention. If the narrative in France was that rapidly diagnosing young people risked labeling as "*malades*" people who would never become one, in the U.S. the frequent claim was that quick diagnosis was crucial to *preventing* someone from becoming mentally ill. The President's Commission on Mental Health lamented in 2003 that only one in two-hundred pre-schoolers received mental health treatment:

> Since children develop rapidly, delivering mental health services and supports early and swiftly is necessary to avoid permanent consequences and to ensure that children are ready for school. Emerging neuroscience highlights the ability of environmental factors to shape

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[58] Qtd. in Matt Compton. 2013. "The National Conference on Mental Health." *Whitehouse.Gov*. Retrieved March 25, 2019 (https://obamawhitehouse.archives.gov/blog/2013/06/03/national-conference-mental-health).

[59] SAMSHA, *Behavioral Health United States*: 23.

[60] Office of the Assistant Secretary for Planning and Evaluation. 2016. *Benefits of Medicaid Expansion for Behavioral Health*. Washington, DC: U.S. Department of Health and Human Services: 2.

[61] Goodman, J. David. March 22, 2019. "$1 Billion for Mental Health: The Reality of de Blasio's 'Revolutionary' Plan." *The New York Times*. Retrieved March 22, 2019 (https://www.nytimes.com/2019/03/22/nyregion/thrivenyc-mental-health-.html).

[62] City of New York, *ThriveNYC:* 8.

[63] New York City's Independent Budget Office. 2017. *Detailing the Expansion of Behavioral Health Services: City-Funded Spending Drives New & Growing Programs Under the Mayor's ThriveNYC Initiative*. New York: 1.

Figure 1.5: Thrive Public Awareness Campaign

> brain development and related behavior. Consequently, early detection, assessment, and links with treatment and supports can prevent mental health problems from worsening.[64]

Many Thrive initiatives similarly sought to head off behavioral problems by expanding counseling in schools or increasing the emotional intelligence of children under five, based on the assumption that "you can save a lot of money by diagnosing people young and getting them into treatment" (Interview, 12/29/16).

Early intervention was coupled with substantial funds to increase public awareness. During my fieldwork, ubiquitous billboard's depicted New Yorkers declaring their diagnoses and announcing that, despite them, they "Thrive" (see Figure 1.5).[65] These ads encouraged readers to call or text a new program, NYC Well, which would provide both immediate crisis counseling and referrals to behavioral health providers. I asked a representative of an association running the program if the program was targeted to those with mental illness, and she replied, "The population served is meant to be quite broad. We definitely don't want to say, 'if your problem is located in a relationship, don't call.' We just want people to call" (Interview, 7/7/17). All told, of Thrive's 54 initiatives, nearly 40% aimed at increasing access to services (Table 1.5), through programs like screening all new mothers who give birth in public hospitals for depression.[66] Thrive, the Commissioner of Mental Hygiene explained, "is really corrective to the narrowness with which we approach the issue, which leaves a lot of people without care, a lot of people untouched…it's precisely the need to widen it that we're trying to fix."[67] The initiative thus looks like a clear example of institutional medicalization through the ever-expanding boundaries of the mental health field.

Less than a fifth of Thrive initiatives sought to improve existing medical services or alter treatment practices. Instead, programs like Mental Health First Aid, which sought to train 250,000 New Yorkers to recognize signs of mental illness, relied on non-medical actors. Explained a person overseeing Mental Health First Aid trainings, "We're not teaching the DSM-V, but we want people to look at a behavior and think, 'I wonder if there might be an underlying mental health issue'"

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[64] President's New Freedom Commission *Achieving the Promise*:: 57.

[65] The conditions in spite of which which people were "thriving" included bipolar disorder, depression, anxiety, and addiction, but not schizophrenia.

[66] City of New York, *ThriveNYC*: 61.

[67] Eisenberg, Amanda. February 27, 2019. "With Opaque Budget and Elusive Metrics, $850M ThriveNYC Program Attempts a Reset." *Politico*. Retrieved March 11, 2019 (https://politi.co/2Tjj4go).

Table 1.5: Comparing Initiatives in France and the United States

	Thrive (New York City) *Total Programs = 54*	*Plan Psychiatrie et Santé Mentale, 2005-2008* (France) *Total Programs = 33*
Public Awareness and De-Stigmatization	16% (9)	9% (3)
Improving Existing Services	3.7% (2)	15% (5)
Expanding Access to Services	38% (21)	21% (7)
Medical Professionals and Practices	15% (8)	15% (5)
Criminal Justice	13% (7)	6% (2)
Special Populations (e.g. children, Veterans…)	44% (24)	9% (3)
Involuntary Treatment and Patients' Rights	2% (1)	15% (5)
This comparison is only suggestive. The French central state and New York City government have very different responsibilities vis-à-vis the health system. However, the two initiatives compared represent similar investments ($305 million in new spending for New York, €287.5 million in France). I chose the 2005-2008 plan in France because, according to my informants, it represented the last plan with real government support and financing.		

(Interview, 7/7/17). The effect was to "empower 'helpers,' like clergy…to give help. Not treatment, help" (Interview, 12/28/16). Underlying this was a project of "task shifting": the notion that, as the Thrive plan laid out, "many types of care, prevention, and promotion initiatives can be provided, at least in part, by a range of non-specialists, including peers, co-workers, and neighborhood groups."[68] Insisted one person involved in the Medicaid redesign, "Managed Care doesn't actually decrease access…Instead, it's about who's going to give the care. They're going to say, 'maybe you don't need to see a psychiatrist for that'" (Interview, 1/11/17). Here we see a more complex version of medicalization: the expansion of mental health care also relied on de-medicalization what that care might actually look like. As the Commissioner articulated in an interview with *The Economist,* Thrive showed how the developed world could "learn from poor countries that mental-health care is not the preserve of qualified specialists."[69] This combination of early intervention, screening, and task shifting, as the commissioner elaborated elsewhere, made Thrive "the first rational approach to the real scope and breath of need."[70]

By 2019, though, Thrive faced an increasing chorus of criticism—albeit one that largely played out on the same terrain of a "Trust in Numbers" frequently questioned in France (Christin 2018; Porter 1996). The City reported that it tracked over 500 indicators, and in its two-year update, laid out Thrive's quantitative impacts: 31,000 contacts to provide counseling to crime victims, 904

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[68] The City of New York. 2015. *ThriveNYC: A Mental Health Roadmap for All.* New York: Department of Health and Mental Hygiene: 57.

[69] The Economist. March 16, 2019. "What Disasters Reveal about Mental-Health Care." Retrieved March 26, 2019 (https://www.economist.com/international/2019/03/16/what-disasters-reveal-about-mental-health-care).

[70] Eisenberg, Amanda. February 27, 2019. "With Opaque Budget and Elusive Metrics, $850M ThriveNYC Program Attempts a Reset." *Politico.* Retrieved March 11, 2019 (https://politi.co/2Tjj4go).

Figure 1.6: Word Cloud of Concepts Discussed in Thrive Focus Groups


To create this graphic, we compiled transcripts from our 25 mental health feedback groups—approximately 50 hours' worth of conversations that informed every aspect of this Roadmap. We then created an infographic illustrates the relative use of the 50 most frequently used non-common words.

schools with mental health consultants, outreach to 4,000 veterans, or 250,000 calls to NYC Well.[71] But, as one critic at the Citizen's Budget Commission noted, "When you're thinking about performance, there's both outcome and output…[The difference is] not simply how many people you've screened or you're training, but what impact that actually has on their life."[72] In setting its goals at the population rather than individual level, the Initiative opened up the question of "whether the investment is going to be enough to move any of the metrics…or show causal relationships," as one City official framed it (Interview, 12/28/16). It wasn't even clear which direction certain indicators should go. As the evaluator from the city explained, "We don't really know if we want the number of people in treatment to go up or down" (Interview, 12/28/16).

This quandary—should the number of people in treatment go up or down?—hinted at a more trenchant but submerged critique of Thrive: that it largely ignoring the classic charges of the public system, the severely mentally ill. While only 3 of 33 initiative's in France's national plan for psychiatry and mental health identified a group more specific than "the mentally ill," nearly half of Thrive's initiatives and 80% of its funding[73] were targeted at specific populations like children, pregnant mothers, university students, or criminally-justice involved persons.[74] The 119-page Thrive plan mentions "schizophrenia" twice and "psychosis" four times (outside of the bibliography); "psychiatrist" makes two appearances and hospitals are mentioned only as something to be avoided. The "word cloud" the city made to highlight key themes from its focus groups on the initiative does not include "illness" (Figure 1.6). Some resented this lack of focus on the hard core of public psychiatry. An advocacy group focused on expanding involuntary outpatient treatment (or "AoT," see Chapter 4) launched a broadside: "100% of [the] population can have mental wellness improved…[but] 4% have serious mental illness. It is the seriously ill, not 'worried well', who become homeless, hospitalized, suicidal, and violent without treatment. We should focus the mental health budget on them."[75]

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[71] The City of New York. 2017. *ThriveNYC: Two Year Update*. New York: Department of Health and Mental Hygiene.

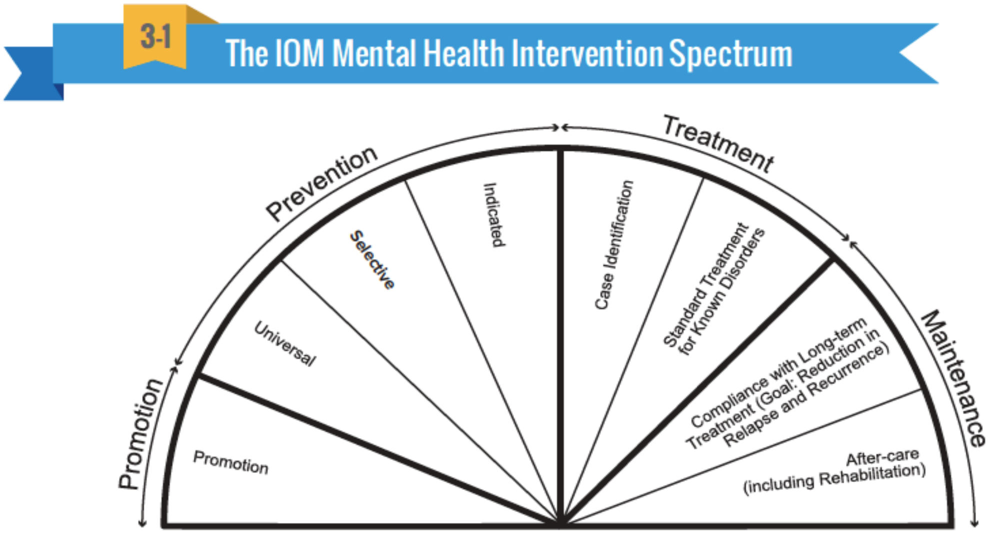
[72] Eisenberg, "With Opaque Budget and Elusive Metrics, $850M ThriveNYC Program Attempts a Reset."

[73] NYC IBO, *Detailing the Expansion of Behavioral Health Services*: 5.

[74] In their analysis of federal government reports, Grob and Goldman (2006:88) similar found that, since the 1970s, more attention was devoted to "special populations" than the seriously mentally ill.

[75] Mental Illness Policy Org. "Why $800 Million Thrive/NYC Is Failing." New York. Retrieved March 26, 2019 (https://mentalillnesspolicy.org/wp-content/uploads/thrivenyc-fails.pdf).

Figure 1.7: New York State's "Intervention Spectrum"



Source: Office of Mental Health. 2016. *Statewide Comprehensive Plan, 2016-2020*. Albany, New York: 21.

A less vitriolic critique of Thrive observed that the initiative was largely pushing people into services without considering whether those services were available or adequate. The head of a major professional organization of outpatient providers opined in testimony to the City Council, "The infrastructure of the community-based providers and their contracts have not kept up with costs…After screening for depression, we must ensure that there are easily accessible on-site or nearby resources…to access services."[76] A lawyer working with severely mentally ill clients raged:

> Why are there posters in the subway trying to convince people they're mentally ill?…We talk all the time about more money to help people have 'access.' But the assumption is always that people have not already accessed mental health care. The problem is that they have and found it wanting (Interview, 12/16/16).

The further I moved up the continuum of care the less professionals knew about Thrive or felt its money was reaching their clients. One haggard-looking inpatient psychiatrist told me, "I don't have a television and I don't have time to watch the news, so I might be out of touch…But in terms of the patients here or the other staff members, I haven't heard anything of consequence" (Interview, 12/9/16).

For some, the municipal government's campaign made for an odd juxtaposition with the state's roll-out of managed care (which was the topic of only one Thrive initiative). As one psychiatrist explained:

> It's going to be hard to evaluate Thrive because it's happening at the same time as a tectonic shift in Medicaid. Thrive isn't about severe mental illness, but it's trying to broaden the system at a moment where the system could completely unravel…Thrive is visionary, but if people get less services because managed care creates more hoops to jump through, it will make Thrive look really bad (Interview, 12/28/16).

Despite these contradictions, managed care and Thrive emerged from a common institutional and cultural base. Each rested on applying tools from other parts of the health system to mental health.

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[76] Parque, Christy. 2017. "Testimony: Oversight - ThriveNYC Update." New York: The Coalition for Behavioral Health. Retrieved March 26, 2019 (http://www.coalitionny.org/policy_advocacy/).

Thrive sought to broaden access to care but, at the same time, lower its intensity, an already well-documented impact of managed care (Frank and Glied 2006; Mechanic et al. 2014). While managed care and Thrive appeared to continue a tradition where the state would focus on the "deep end of the pool" and the city on "filling in the gaps" (Interview, 1/10/17), the two were complementary insofar as mental health and mental illness existed on a continuum (see Figure 1.7). Acting early and strategically was a rational way to contain costs, prevent illness, and, at least in concept, improve population health in a way that was visible through epidemiological and could meet societal demands for bureaucratic accountability. A focus on delivering care over time to "real *malades*" was unnecessary insofar as a rationalized system might have no real *malades* at all.

Allocating: Granting Services to Reduce and Navigate Service Use in California

Compared to France—where there were no official criteria for public psychiatric care—and New York—where those criteria were in flux—California represents a case where criteria and decision-making processes for allocating care were formalized, elaborate, and, at least in the clinic I observed, largely observed. Post-Affordable Care Act, California created a bifurcated system. As the state Department of Health Care Services spelled out in a memorandum, new demands for care should be "assessed by a licensed mental health professional through the use of a MediCal [California's version of Medicaid] clinical tool."[77] Those found to have "mild" to "moderate" impairments as a result of a qualifying diagnosis would receive medication management or outpatient services through a general managed care plan. Plans would make decisions based on a classic suite of rationalized criteria: the "medical necessity" of the service "consistent with evidence-based clinical practice," alongside consideration of "appropriate service usage" "cost and effectiveness" "service alternatives" and "potential fraud, waste, and abuse."[78]

Clients with "severe" impairments "in an important area of life functioning" and for which mental health care would have the "expectation…[to] significantly diminish the impairment"[79] would be sent to specialty mental health plans funded by individual counties. Counties would then make their own assessment, using an "algorithm" that considered factors like emergency department usage or co-morbid physical conditions (see Figure 1.8). The resulting system, one critical report noted, had "expanded the scope of mental health benefits available to MediCal beneficiaries" but had "made delivery and access to these services more complicated,"[80] as the state's own flowchart for assigning levels of care clearly (if inadvertently) shows (Figure 1.9).[81] As I argue in this section, at ground level Californian clinicians rationalized care in large part by demedicalizing the cognitive categories used to assign care and the normative aims of their work.

The clinic I studied was the main provider in a medium-sized city for one of these county mental health plans. It thus had a clear mandate to service only clients whose diagnosis of mental illness led to "severe" impairments. But even within that, care was carefully delineated. For clients that met (or might meet) the severity threshold, the clinic could offer four levels of care, in

---

[77] Department of Health Care Services. 2017. *MediCal Managed Care Plan Responsibilities for Outpatient Mental Health Services.* Sacramento, CA: 3. This notion that evaluation should be standardized was also part of New York's Medicaid redesign, which instructed "Managed care entities should be required to use standardized assessment and level of care protocols which should be made available to all network providers." Behavioral Health Reform Work Group. 2011. *Medicaid Redesign Team: Final Recommendations.* Albany, NY: New York State Department of Health: 13.

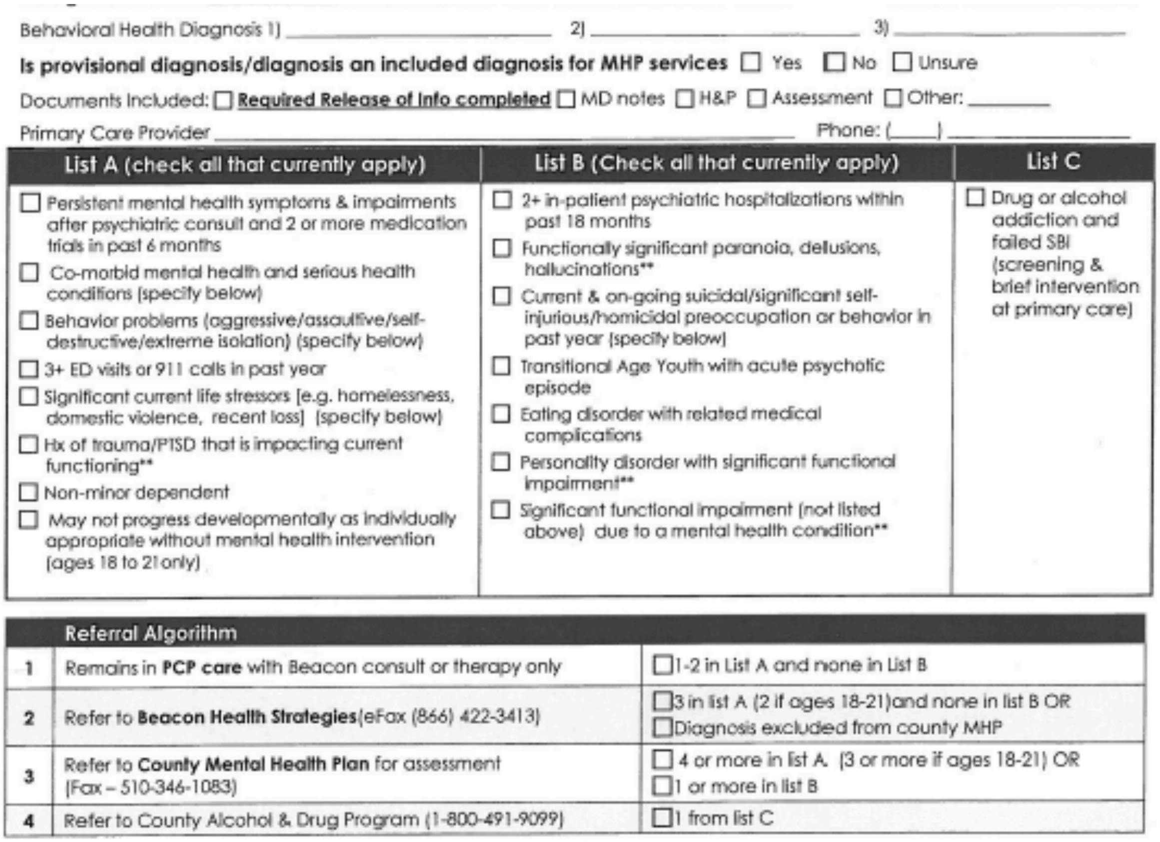
[78] DHCS, *MediCal Managed Care Plan Responsibilities.*

[79] Ibid.

[80] Lewis, Kim and Abbi Coursolle. 2017. *Mental Health Services in Medi-Cal.* Los Angeles, CA: National Health Law Program: 1.

[81] Given this complexity, I am grateful to Didi Wu for her help understanding it.

Figure 1.8: California County Referral Form



Behavioral Health Diagnosis 1) __________ 2) __________ 3) __________

Is provisional diagnosis/diagnosis an included diagnosis for MHP services ☐ Yes ☐ No ☐ Unsure

Documents Included: ☐ **Required Release of Info completed** ☐ MD notes ☐ H&P ☐ Assessment ☐ Other: ________

Primary Care Provider __________ Phone: (____) __________

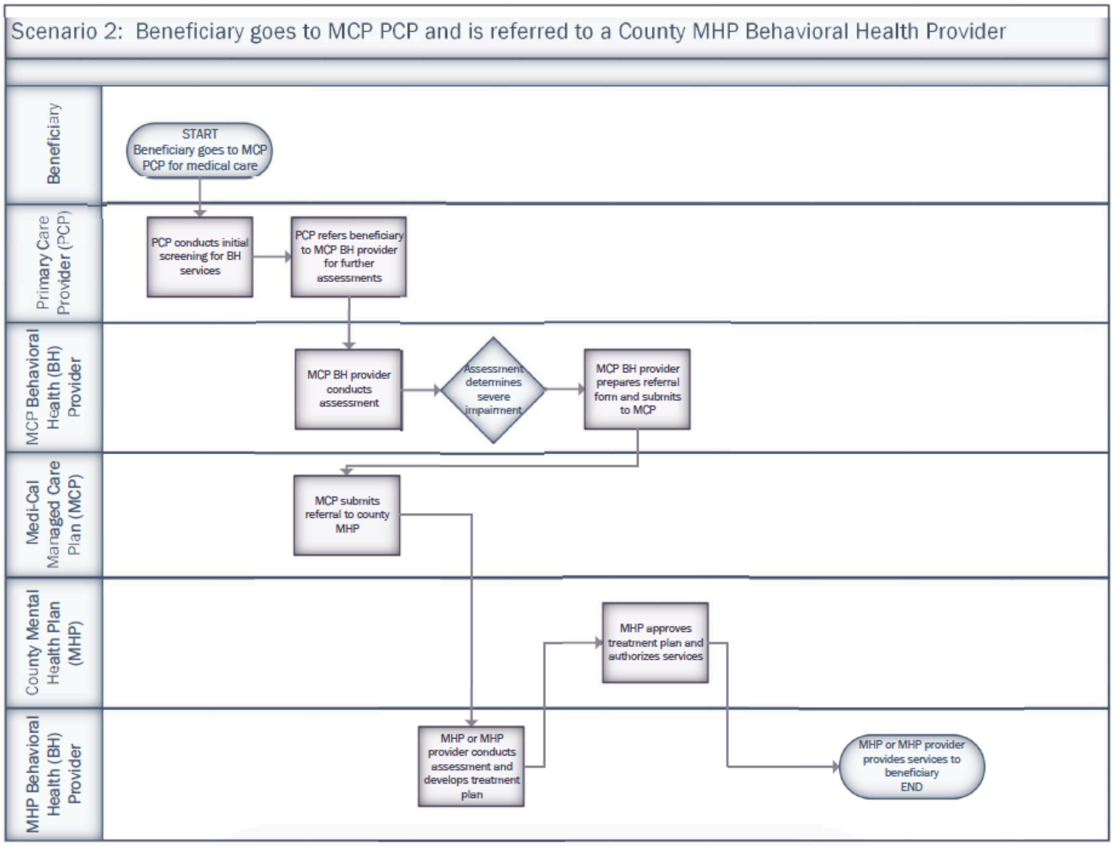
List A (check all that currently apply)	List B (Check all that currently apply)	List C
☐ Persistent mental health symptoms & impairments after psychiatric consult and 2 or more medication trials in past 6 months ☐ Co-morbid mental health and serious health conditions (specify below) ☐ Behavior problems (aggressive/assaultive/self-destructive/extreme isolation) (specify below) ☐ 3+ ED visits or 911 calls in past year ☐ Significant current life stressors [e.g. homelessness, domestic violence, recent loss] (specify below) ☐ Hx of trauma/PTSD that is impacting current functioning** ☐ Non-minor dependent ☐ May not progress developmentally as individually appropriate without mental health intervention (ages 18 to 21 only)	☐ 2+ in-patient psychiatric hospitalizations within past 18 months ☐ Functionally significant paranoia, delusions, hallucinations** ☐ Current & on-going suicidal/significant self-injurious/homicidal preoccupation or behavior in past year (specify below) ☐ Transitional Age Youth with acute psychotic episode ☐ Eating disorder with related medical complications ☐ Personality disorder with significant functional impairment** ☐ Significant functional impairment (not listed above) due to a mental health condition**	☐ Drug or alcohol addiction and failed SBI (screening & brief intervention at primary care)

	Referral Algorithm	
1	Remains in **PCP care** with Beacon consult or therapy only	☐ 1-2 in List A and none in List B
2	Refer to **Beacon Health Strategies** (eFax (866) 422-3413)	☐ 3 in list A (2 if ages 18-21) and none in list B OR ☐ Diagnosis excluded from county MHP
3	Refer to **County Mental Health Plan** for assessment (Fax – 510-346-1083)	☐ 4 or more in list A. (3 or more if ages 18-21) OR ☐ 1 or more in list B
4	Refer to County Alcohol & Drug Program (1-800-491-9099)	☐ 1 from list C

descending order of intensity: "Full Service Partnership" (FSP), "Intensive Case Management" (ICM), "Commitment to Community Living" (CCL), and "Extended Therapy" (ET). "There is a big concern about equity" about these decisions, reported one psychologist, elaborating "we are really worried about having a consistent process to address these issues and assign care" (Interview, 1/19/18). When a team leader asked for freedom to determine what to do with a difficult client, the program director lectured, "As we know, when we say that we use discretion, it creates inequity—we serve the clients we like, and make the ones we don't leave" (Fieldnotes, 1/11/19). To counter this potential bias, the Clinic Director created a flow chart spelling out the criteria for each level of care, which became a ubiquitous reference point in moments of uncertainty or conflict during the meetings (Figure 1.10). Like the French clinicians, those in California had an expressed commitment to serving the most difficult cases; they just didn't trust themselves to determine who those really were to the same degree.

The most contentious moments came during debates over who to assign to FSP. California's Full-Service Partnerships were founded on the idea that mental health providers should leave the physical clinic and serve clients in the community, meeting them "where they are at" and "doing whatever it takes" to keep them there (see Brodwin 2012; Cashin et al. 2008; Estroff 1981). In one study, FSP teams spent three times more minutes (MediCal billing requires that level of accounting for clinicians' time) with their clients than those with comparable severity in traditional outpatient services (Starks et al. 2017). The City's FSP team had a generous twelve-to-one client-to-staff ratio, the ability to go in teams to meet its sixty clients multiple times a week and, perhaps most importantly, funds to pay for housing. It was an intensity of care that did not exist at all at the French CMP and was, unsurprisingly, expensive, at $18,000 per client per year.

Figure 1.9: State Level of Care Flowchart



Source: Department of Health Care Services. Retrieved March 27, 2019 (http://www.dhcs.ca.gov/services/Pages/Medi-CalMentalHealthServicesReferralProcesses.aspx*)*.

Both in regulation[82] and in practice, clients on FSP received the best outpatient services due to their previous overuse of the worst (read: expensive) elements of the social service system. A clinician explained the logic:

> Counties in California pay for inpatient psychiatric hospitals, so leadership in the counties recognized that they needed outpatient treatment teams to back up all that expensive inpatient care. So they circulated lists of 'high costs' individuals, and the outpatient teams that reduced those costs got expanded contracts, and those that didn't lost them. So the system evolved (Interview, 3/15/19).

At the Clinic, the basic threshold for FSP was to hit three of the following risk factors: "Co-occurring substance abuse or medical conditions," "Transitional-age youth or older adult," "Repeated, recent hospitalizations [measured either in the number of days or admissions]," "Homelessness or risk of homelessness," and "Criminal justice involvement."[83] Afterwards, the team had to also determine if the client posed enough risk that they needed to be met by teams rather than individual clinicians, and if, absent enhanced services, they might "fail" in the community, meaning long-term internment in a hospital or jail.

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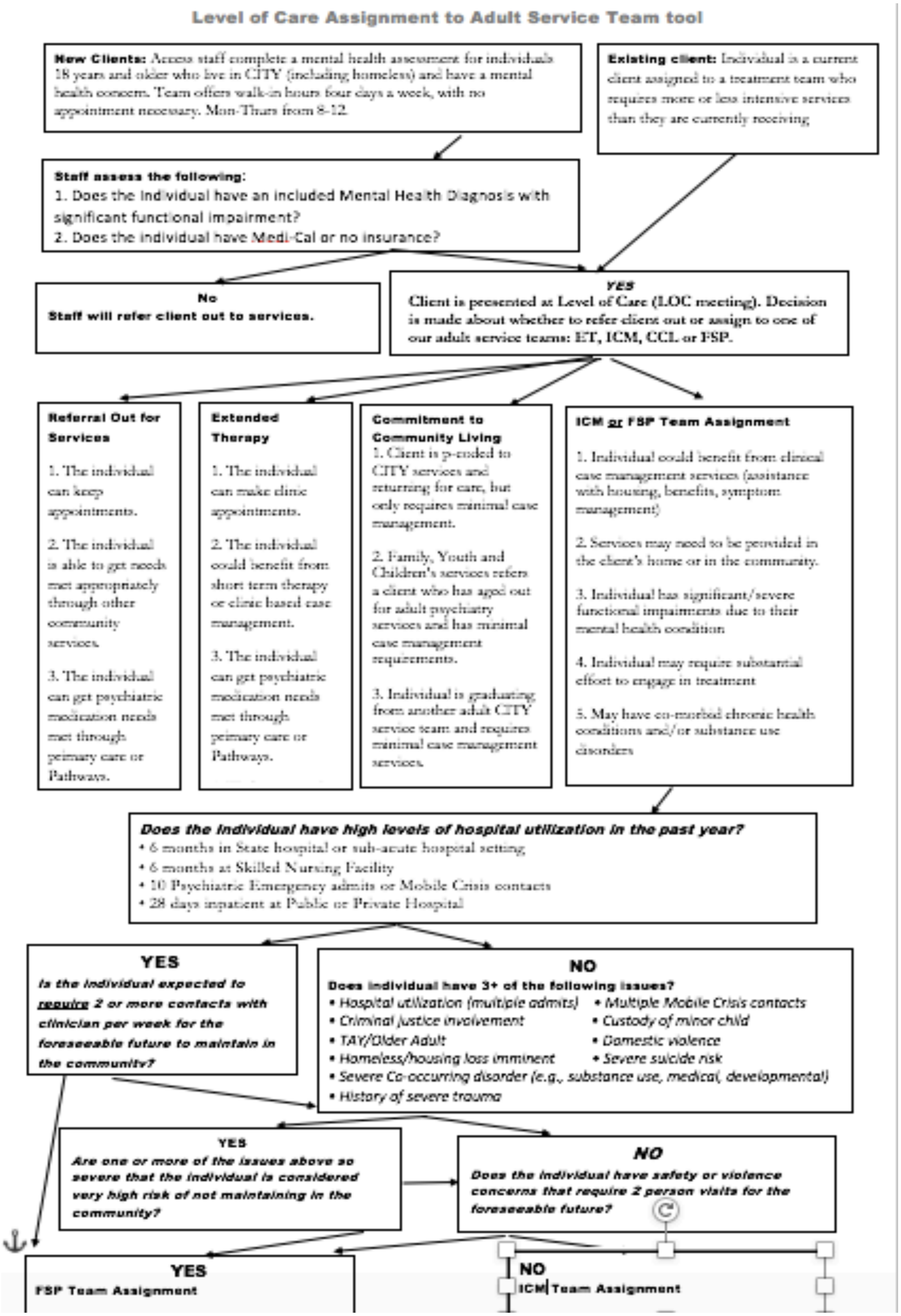
[82] Department of Mental Health. April 10, 2009. *Clarification on Requirements for Full-Service Partnerships (FSP) under the Mental Health Services Act (MHSA)*. Sacramento, CA. Retrieved March 28, 2019 (https://www.dhcs.ca.gov/services/MH/Documents/FSP_FAQs_04-17-09.pdf).

[83] These were expanded over the course of my fieldwork – Figure 1.10 has the most recent list.

Figure 1.10: Clinic Level of Care Assignment Tool



Level of Care Assignment to Adult Service Team tool

New Clients: Access staff complete a mental health assessment for individuals 18 years and older who live in CITY (including homeless) and have a mental health concern. Team offers walk-in hours four days a week, with no appointment necessary. Mon-Thurs from 8-12.

Existing client: Individual is a current client assigned to a treatment team who requires more or less intensive services than they are currently receiving

Staff assess the following:
1. Does the individual have an included Mental Health Diagnosis with significant functional impairment?
2. Does the individual have Medi-Cal or no insurance?

No
Staff will refer client out to services.

YES
Client is presented at Level of Care (LOC meeting). Decision is made about whether to refer client out or assign to one of our adult service teams: ET, ICM, CCL or FSP.

Referral Out for Services

1. The individual can keep appointments.

2. The individual is able to get needs met appropriately through other community services.

3. The individual can get psychiatric medication needs met through primary care or Pathways.

Extended Therapy

1. The individual can make clinic appointments.

2. The individual could benefit from short term therapy or clinic based case management.

3. The individual can get psychiatric medication needs met through primary care or Pathways.

Commitment to Community Living
1. Client is p-coded to CITY services and returning for care, but only requires minimal case management.

2. Family, Youth and Children's services refers a client who has aged out for adult psychiatry services and has minimal case management requirements.

3. Individual is graduating from another adult CITY service team and requires minimal case management services.

ICM <u>or</u> FSP Team Assignment

1. Individual could benefit from clinical case management services (assistance with housing, benefits, symptom management)

2. Services may need to be provided in the client's home or in the community.

3. Individual has significant/severe functional impairments due to their mental health condition

4. Individual may require substantial effort to engage in treatment

5. May have co-morbid chronic health conditions and/or substance use disorders

Does the individual have high levels of hospital utilization in the past year?
- 6 months in State hospital or sub-acute hospital setting
- 6 months at Skilled Nursing Facility
- 10 Psychiatric Emergency admits or Mobile Crisis contacts
- 28 days inpatient at Public or Private Hospital

YES
Is the individual expected to <u>require</u> 2 or more contacts with clinician per week for the foreseeable future to maintain in the community?

NO
Does individual have 3+ of the following issues?
- *Hospital utilization (multiple admits)*
- *Multiple Mobile Crisis contacts*
- *Criminal justice involvement*
- *Custody of minor child*
- *TAY/Older Adult*
- *Domestic violence*
- *Homeless/housing loss imminent*
- *Severe suicide risk*
- *Severe Co-occurring disorder (e.g., substance use, medical, developmental)*
- *History of severe trauma*

YES
Are one or more of the issues above so severe that the individual is considered very high risk of not maintaining in the community?

NO
Does the individual have safety or violence concerns that require 2 person visits for the foreseeable future?

YES
FSP Team Assignment

NO
ICM Team Assignment

On the ground, the Clinic's staff grappled with whether the FSP criteria actually gave services to the clients who most needed it, when they needed it. The team debated the case of a 60-year-old black man (over half of FSP clients were black, in a city where fewer than 10% were) who had "schizophrenia spectrum disorder" and was recently hospitalized for making death threats to the employees of a local bookstore:

> *MCT Psychologist:* So, do we know why he was being violent and disruptive?
>
> *Intake Social Worker:* Alcohol. He seems motivated to go into recovery now, though. He brought himself in.
>
> *Psychiatrist:* Okay, but he should not be served in the clinic. He belongs on FSP and needs to be served in the community.
>
> *FSP Director:* What are his case management needs?
>
> *Intake Social Worker:* I talked to him and asked, 'Do you want to stay out of jail? Do you want to stay out of the hospital?'
>
> *FSP Director:* You're a bit 'leading the witness' there…
>
> *MCT Psychologist:* That's what we do!
>
> *Clinical Director:* The problem is that what's happening is an escalation, but he doesn't meet FSP criteria based on his current use of the system. But he's heading there.
>
> *Intake Social Worker:* Can we qualify him based on safety? He has had four 5150s [involuntary hospitalizations] in four months…
>
> *Psychologist:* Okay, we put him on FSP. But he won't last long. In any case, this whole thing reeks of meth (Fieldnotes, 3/15/18).

The next week, the intake worker reported, "He came back and said that he didn't want services." "So we close his file?" the MCT psychologist asked. "Sure. Someone like this is going to show up again. If he winds up in the hospital, we'll catch him then" (Fieldnotes, 4/13/18).

The case spoke to several tensions and paradoxes within the FSP model. Despite narratives of the decline of hospitalizations in the U.S., 58% of new cases at the Clinic had a recent history of hospitalization (even if those hospitalizations were for a matter of just a few days or hours). But while hospitalization was the most sure-fire way to qualify for public mental health services (as in France), the outpatient teams had almost no control over when someone was hospitalized or when they would be discharged (unlike France). Second, as the Adult Clinic Director put it, the best time to try to engage clients was "while they're a captive audience" (Interview 4/27/18) in jail or a hospital, because once they departed, outpatient services were purely voluntary and anyone could—like the case above—refuse services, even if the result was that they would be involuntarily hospitalized again. Finally, the official guidelines for FSP qualified some people based on non-medical criteria that most of the team thought meant they would fail. As the FSP team director explained:

> I've been doing this for 18 years, and now we have 80% of people for whom the main issue is substance abuse. We have fewer and fewer people with what I would call classic severe mental illness. Instead, we're moving towards people whose lives are complicated by substance abuse. They might have bipolar, but it would be manageable if they weren't on meth (Interview, 12/18/18).

The omnipresence of drug use, particularly for clients assigned to FSP, was confirmed in my data (see Table 1.2). The quantitative criteria—does this person have a sufficient number of incarcerations, hospitalizations, or crisis contacts?—overwhelmed qualitative and typological ones like those used in France—is this person really mentally ill? The result was that, cognitively, the team reasoned in primarily non-medical terms. Indeed, the rational criteria that the team used to grant outpatient services in order to reduce other forms of service use gave them little capacity to refuse services even to those who barely met the diagnostic threshold.[84]

Like the policymakers behind Thrive, clinicians believed that even at the more extreme ends of the spectrum there were many people in their catchment area who needed treatment but were not receiving it. The psycho-analytically oriented community clinics of the immediate post-deinstitutionalization period saw waiting lists as a "useful screening mechanism" that "reduc[ed] workload in a rational way" (Robin 1976:138) by limiting care to those who demanded it, similar to what happened in France. The city clinic I studied, in comparison, had rolled out and expanded mobile crisis (MCT) and homeless outreach teams (HoTT), which actually generated sometimes half-hearted demands for services. An MCT clinician presented the case of a 41-year-old white woman with "somatic symptom disorder." Her intake sheet noted that she had seen HoTT seventy times in the last year and Mobile Crisis twice.

> *MCT Psychologist:* She is in constant crisis in the community, and very high profile. We've paid for a few nights in a hotel just to calm her down.
>
> *Intake Social Worker:* And is she, like, homeless-on-the-street homeless?
>
> *MCT Psychologist:* Yes. Her exaggerated somatic complaints—she claims her six-year-old has 'whooping cough'—mean that she's refusing to live in a shelter. She's denying substance abuse, but we have collateral from the [homeless] encampment that says otherwise.
>
> *City Mental Health Director:* Oh—this is the one where she was living in a rat-infested, moldy RV, and the city took it away. She went to the city council meeting and talked so long they had to go into recess.
>
> *MCT Psychologist:* Right. So we have pressure from the city manager to do a full court press here. Clearly her medical beliefs have been blocking her from getting services, but she came to an intake, even if she claims the reason is that we are a 'powerful' force that she would like to have as a 'friend not a foe.'

The team reviewed her case history: she lived off of social security disability, had been homeless since 2004, and had contact with the criminal justice system only through reporting her ex-husband for domestic violence. The psychiatrist began the level of care discussion in earnest:

> *Psychiatrist:* So why is this FSP?
>
> *MCT Psychologist:* Because of the number of contacts. She has a kid and could use a team approach, too.
>
> *FSP Director:* Well, this is someone who made it forty years without being in the system. There are risk factors here in terms of homelessness and a kid but… I see the number of contacts, but we're generating those ourselves. It's not a classic presentation.
>
> *ICM Director:* I agree it's not a classic client. But the times are a changin'. The system is more inclusive, and we have more and more non-typical people.
>
> *Intake Social Worker:* I don't think ICM can provide the level of contact she needs.
>
> *FSP Director:* Does she need that much contact, or are we just providing it?
>
> *MCT Psychologist:* Look, the city wants to wash their hands of her. The goal is to do whatever is necessary to get her to a point of stability. HoTT has done everything it can to get her into treatment. Now she's here.
>
> *FSP Director:* We traditionally do not have much success with people like this. She sounds like she has a borderline personality, which means she'll play people off one another. We [a team approach to care] are basically contra-indicated.

---

[84] When set up, FSPs were expected to receive only 20% of their clients as transfers from existing levels of care, as opposed to people currently receiving no services (Starks et al. 2017).

> *Psychiatrist:* Well we should give her FSP, we document our efforts, and then we can make the case for withdrawing it.

The FSP director frowned and declared, "I capitulate." The psychologist asked, "When do you want to do the transfer?" and he replied, "How about 2024?" (Fieldnotes, 12/7/18).

The next week, I was able to attend the presentation of the new client to the whole FSP team. After running through much the same information as the initial level of care discussion, the clinician emphasized:

> *MCT Psychologist:* One of her strengths is that for a long time she was able to stay under the radar and avoid law enforcement. But now she's using her service providers a lot… she's open to care because she knows we have resources and wants those resources. But on some level, I think she knows she needs care.
>
> *FSP Team Member:* What is 'somatic symptom disorder'?
>
> *MCT Psychologist:* Uhh… Well, she didn't quite meet criteria for a personality disorder… She did have a bike fork driven through her eye two years ago, so it might be a nervous system thing.
>
> *FSP Director:* And what does she actually think is going to happen with case management and a treatment team? Does she even want to see a psychiatrist?
>
> *MCT Psychologist:* She believes she has PTSD and a brain injury, so whatever we prescribe should align with her beliefs about her medical needs. For case management… She definitely wants housing. She needs coaching to navigate the system, get her kid to school…
>
> *FSP Director:* Well, I recently shared an article about why these cases don't work with our approach. But we'll try (Fieldnotes, 12/12/18).

When I caught up with the FSP Director later, he confirmed, "There's no way we would have taken her if it weren't for the city council" (Interview, 12/18/18).

I consider this case at length because it presents so many stark contrasts with clinical reasoning in France. The woman's symptoms and diagnose were vague; what was crystal clear was her escalating service use and her visibility in the community. The case was, to an extent, dually de-medicalized. Her demand was above all for housing, not treatment; what the FSP team would provide was, above all, case management, maybe with medication added in. This fit with a broader trend by which public mental health services in the U.S. have moved away from altering peoples' inner mental states towards "case managing" their interactions with other institutions (Brodwin 2012; Floersch 2002). The team's willingness to "align with her beliefs about her medical needs" spoke to their limited interest in the normative goal of getting her to adopt a medicalized subjectivity. One clinician confirmed, "At some point, we stopped doing psychoanalysis, and started teaching people how to solve problems, like using a phone and paying bills" (Interview, 3/15/19). This was much the same transformation being pushed in New York with the shift to managed care.

For the clinic's one-step lower level of care—Intensive Case Management—the key criterion was less about peoples' *over*use of services and more their *inability* to navigate other services based on a "functional impairment." Unlike the CMP, the Clinic was densely imbricated with other social services, like drop-in centers for the homeless, shelter, senior centers, and law offices helping people apply for disability; these kinds of institutions provided around 18% of referrals, tying with hospitals as the primary source of new cases (Table 1.3). When these potential clients arrived, some were asking for medication (rarely therapy), but equally frequently help applying for housing or obtaining government benefits. Diagnosis was a necessary but insufficient condition for ICM services: one woman, for example, was diagnosed by the intake worker as having "PTSD," "schizophrenia," "amphetamine use disorder," "tobacco-use disorder" and "homelessness," but the sheet observed that she had previously been diagnosed with "depression, schizo-affective disorder, bipolar disorder, panic attacks, meth use disorder, and intermittent explosive disorder," the last of these provoking widespread guffaws. In any case, her level of care discussion focused on the City Department of Aging Services' report of her difficulty navigating waitlists for supportive housing, not refining her diagnosis (Fieldnotes, 7/13/18).

Appropriate ICM clients were thus those for whom a combination of treatment (mostly in the form of medication or brief psychotherapy) plus weekly engagement with a case manager would help them develop the social supports necessary to remain in the community, regardless of their medical symptoms. The intake worker reported on a fifty-six-year-old Latino man brought in by his housemates:

> *Intake Sheet:* Client is well-groomed and clean but emaciated and nearly catatonic. Nearly non-verbal with limited thought content, extreme difficulty tracking the conversation. Needs natural support. Three recent hospitalizations but no criminal justice contacts. Risks of homelessness and has lost SSI income.
> *Intake Social Worker:* This is someone who had no contact with the mental health system before fifty-four. About five months ago, his symptoms reappeared after a period of stabilization. We think it's tied to the fact that he was running out of workers' comp and losing his private insurance. He stopped using marijuana, probably because he ran out of money. He's stopped eating and lost 25 pounds in three weeks. I almost tried to hospitalize him for grave disability.
> *ICM Director:* The centerpiece here is going to be connecting him to benefits. The fact that he has no insurance should be put up front in the summary [on the intake sheet] (Fieldnotes, 8/3/18).

Connecting clients to the right social services—in this case, disability income and Medicaid—and to teach them to manage themselves was the normative goal of "treatment" and would prevent them from falling into the homelessness or hospitalization that would shift them onto FSP. This individual's symptoms were the ultimate barrier to his community tenure, which was why the client was seen as an "appropriate case" for the Clinic, but reducing them was not the most pressing issue.

The Clinic's lowest long-term level of care, Commitment to Community Living, existed for clients stepping down from FSP or ICM once their housing was stable, their use of emergency services decreased, and their case management needs could be handled with a once-a-month contact. The priority of keeping people in the community, above all else, was evident in the fact that the CCL team had at least some clients who weren't taking medication at all, but whose housing vouchers or parole officers required they be "in treatment." In turn, CCL clients could be smoothly and unproblematically bumped back up to ICM when their ability to navigate life in the community was in question, as in the case of a 44-year-old black woman with schizophrenia:

> *CCL Director:* She has no recent hospitalizations or criminal justice contacts, with limited heroin use. But right now, she's at risk of losing housing because she's not paying rent. That means homelessness for her and her child. She's refusing meds but will accepting housing support.
> *Clinic Director:* So she's disengaged with any case management?
> *CCL Director:* Not really, just not taking the meds.
> *Clinic Director:* So the idea is, with more regular case management, she'll engage more with treatment? It doesn't matter, I guess, a threat to housing is enough…
> *FSP Director:* Are there any behavioral issues that might lead her to stop paying rent?
> *CCL Director:* She had white powder on her nose when we saw her (laughs).
> *FSP Director:* Okay. Sounds like it's time we become the payee for her social security check.[85]

---

[85] A "payee" is the person designated to receive and disburse a disabled person's social security check.

> *Psychiatrist:* I'll do the paperwork.
>
> *Clinic Director:* Great. We move her up to ICM based on her housing status (Fieldnotes, 8/3/18).

Cases like these were emblematic of how clearly-defined criteria, accepted as legitimate by the range of professionals in the clinic, provided the basis for consensual calibration of care. The logic of rationalization, at ground level, dictated that outpatient mental health should ensure clients used the 'right' social services as part of a shared goal of keeping clients out of institutions at manageable costs. The variable "whatever" of the "whatever it takes" to achieve that goal was frequently non-medical.

Exits and Exclusions: Calibrating and Withdrawing Care

This final section considers the contradictions and limits of the American logic of rationalizing care, visible in the moments where professionals at the Clinic fought over formal criteria, sought to refer clients out to services that did not exist, and struggled with a mandate to move patients down and out of the care continuum. As noted above, the FSPs in California were intended to target people who were "high utilizers" of the wrong services as a result of being "under-served" by quality outpatient ones (Gilmer et al. 2013). Over the course of my fieldwork, the clinicians spoke more and more about how these two criteria did not always overlap. As the MCT Director told me:

> We are concerned about equity…[because] women are typically not as violent—this is definitely not always true!—but they frequently have less criminal justice involvement. They are more likely to have PTSD and engage in avoidant behavior. So how do we make sure they're also getting care?" (Interview, 1/19/18).

One day, the intern presented the case of a woman diagnosed with major depression and PTSD.

> *Clinic Director:* So she's already getting medication from [Private Outpatient Clinic]?
>
> *Intern:* Yeah, she's a very tough one [to decide if she qualifies].
>
> *ICM Director:* It says she was homeless for 27 years but now she's… actually housed.
>
> *Intern:* If you can believe it, she has a bachelor's degree and was working. But she lost her job and her insurance and… if you look to her, she's cut her arms from here to here [motions the entire length of her arm].
>
> *City Mental Health Director:* So, to be clear, there haven't been any hospitalizations, just two visits to the ER?
>
> *MCT Director:* Yes but… look at this history. She has had to prostitute herself. There's a crazy history of abuse. She could really benefit from a strong relationship with a therapist and a bit of case management. It's true she's been savvy and stayed out of the hospital…
>
> *ICM Director:* I'm seeing from the intake that there are multiple rapes and suicide attempts.
>
> *Intake Social Worker:* There are periods when she doesn't eat…

The team continued to express dismay at the range of suffering coming through in her write-up, but the City Mental Health Director moved to bring the conversation to a close:

> *City Mental Health Director:* Well, she doesn't really meet our criteria. There's no hospitalization, and she's not homeless. But we know that we under-serve women and people with trauma tend to under-report their symptoms. So given that, I'm okay with serving her.
>
> *ICM Director:* This really isn't a fit for our services. Could we just refer her out [to a private therapist]?
>
> *MCT Director:* I'm not sure she's actually make it…

> *City Mental Health Director:* Let's try it [ICM]. We'll focus on the clinical dimension here. She has trauma, and the idea is to develop a therapeutic relationship. We need to focus on that, rather than trying to get her to do stuff in terms of case management (Fieldnotes, 1/11/19).

The case was remarkable for its asymmetry with France. The CMP frequently rejected people who were showing up in the system as a result of perceived character flaws or substance use; the Clinic rapidly qualified these individuals for services. But the kind of person whose severe symptoms or suicidality might have easily bumped them into the range of "real *malade*" (at least, if it was not a "reaction" to social circumstances) needed an exception for public mental health in California. This case attracted acute interest in part because it presented a relatively rare opportunity to do what French clinicians thought they were doing all the time—treating disordered subjectivities.

As in France, providing care to the people the Clinic saw as most deserving meant withholding it from others. In a rationalized system, though, both who was supposed to be referred out and where they were supposed to go was more clearly enumerated. For example, there was a hard "no" towards treating any clients with private insurance. On the other hand, the expansion of Medicaid under the Affordable Care Act had been "like a firehose" of new clients coming to the clinic to demand care (Interview, 4/27/18); three-quarters of them would be referred back to the county access hotline, which would in turn direct them to a private clinic financed through Medicaid managed care. This process came up in a Friday meeting:

> *ICM Director:* We need some way we can actually explain this to people who come in and say, 'I need a case manager' and we say, 'we can't help you.'
>
> *Psychiatrist:* Basically, say we have four criteria. You need MediCal, you need to live here, you need a serious mental illness with functional impairment…
>
> *Clinic Director:* [jumping in] And you can't be served elsewhere! Some people with severe functional impairment can still make their own appointments or get housed.
>
> *FSP Director:* Of course, some of those private clinics, they pretty much treat you like cattle (Fieldnotes, 5/4/18).

The social worker who handled intakes confirmed with me:

> It's really important for me to figure out whether someone could pursue things in a complicated system, whether it's housing or getting a phone. So I was to know, 'Do I think they can make it to an appointment?' Some people have really severe mental illness, but they only need psychiatry or psychotherapy, and that person is referred out (Interview, 3/15/19).

Ironically, given how much more extensive social services are in France, the U.S. clinicians perceived themselves as existing within a dense ecology of social service agencies that both sent them clients and could take those that did not qualify for the Clinic's services. Here, matching could be done based on the person's case management needs (or lack thereof) and their capacity to meet them elsewhere. These cases showed both the institutional penetration of the mental health system *and* the extent to which its goals and the reasoning around how to achieve them were frequently coterminous with non-medical agencies of poverty governance.

The presumption, of course, was that this network of providers could actually provide. Yet once I started scratching, it was clear how much of an assumption this was. The person who managed the county access line, for example, told me that 50% of the people they assigned did not make a first appointment (Interview, 5/27/18). As the Clinic's psychiatrist confessed, "There's a therapist network out there, but they don't return calls, they cap the number of people on MediCal because it doesn't pay well, they're too busy, or they're dead. Those lists are horrendous. If someone is high functioning, they can connect, but I don't know about the rest" (Interview, 1/25/19). Applying fixed criteria to clients in a fluctuating state meant that, in California, people are "referred back and forth" with people experiencing "gaps in services or are forced to change providers when the severity of their condition changes."[86] This movement was, in some ways, precisely what a rationalized system sought: a dynamic and ongoing calibration of care to ensure that people did not linger too long in one service or another. The intake social worker told me, optimistically, "It's hard to reject people, but I finesse it and say, 'You can always come back and have another assessment.' I never say, 'you don't have access,' I say, 'I can help you, just not here'" (Interview, 3/15/19). The flat "yes" or "no" of rationing gave way to a multitude of equivocal promises of "yes, for now'" and "yes, but elsewhere."

Over time, of course, even those clients who were initially served in the public system were supposed to step down and out of it.[87] The whole rationalized system rested on a common construction of (partly non-medical) service needs as fluctuating, even if medical symptoms were chronic (although, as I show in Chapter 3, this lack of attention to chronic illness was facing increasing criticism by the end of my fieldwork). The California FSP I studied really did manage to achieve the program's goal of reducing service use: an annual report summarized an 86% decrease in days spent in the hospital, an 87% reduction in days spent incarcerated, and a 68% fall in days spent homeless.[88] These improvements came only partly from better medications or psychiatric expertise. They rested in large part on the shoe-leather of caseworkers who tracked down clients, brought them their insulin and delivered injections in homeless encampments, haggled to get them released from jail, and brought them to appointment after appointment to navigate the county's byzantine housing wait lists.

Rather than simply defaulting to once-a-month psychiatry appointments when a crisis was over, as in France, the team in the U.S. actively discussed how to step clients down. Often, these shifts were as much about invisibility as stability; that is to say, clients could move to lower levels of care simply by ceasing to show up on the radar screen of police, hospitals, or the city council:

> *Case Manager:* This is a client who was homeless in a tent, now she's in a supported housing. She gets along with her building manager… a bit less so with the other tenants, but it's okay. She still has delusions and hears voices all the time, but she adamantly does not want medication. She needs to stay with us to keep her housing voucher.
>
> *Intake Social Worker:* I remember her! She was really lovely until she talked about stabbing people in the eyes with pencils…
>
> *Case Manager:* She hasn't been violent.
>
> *MCT Director:* Well, good work. Let's move her down to Commitment to Community Living (Fieldnotes, 3/15/19).

The woman was refusing the main service CCL provided—medication management—but continued check-ins from a Clinic case manager would allow her to keep her housing, which, combined with her behavioral control, was on balance a positive outcome. Although according to Gong (2017) the awareness of one's illness and need for medication to treat it ("insight") is the lodestar of contemporary community care, many clients stepped down despite medication non-compliance.

The ultimate goal of "recovery," in fact, often went beyond simply developing "natural supports" in the community alongside medical ones, but ultimately meant "independence in general and, especially, independence from the mental health system" (Dobransky 2014:37) entirely. In truth, although the idea of stepping people out of the public system into private clinical care was

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[86] Lewis and Coursolle, *Mental Health Services in Medi-Cal*: 6.

[87] An audit of behavioral health services in San Francisco called for FSPs to "maintain the balance between referrals to and discharges from" intensive services. San Francisco Budget and Legislative Analyst. 2018. *Performance Audit of the Department of Public Health Behavioral Health Services*. San Francisco, CA: v.

[88] The numbers have been changed to preserve anonymity.

frequently discussed, I almost never saw people leave the public system through a smooth ratcheting down of care (see Table 1.4). More frequently, people disappeared (33%), refused services (30%), or moved to another county (17%).

> *Clinic Director:* This is the case of a forty-six-year-old white male, diagnosed with schizo-affective disorder. He's been disengaged since he left his housing in 2016. He was on CCL, moved up to ICM, and then was hospitalized for psychosis. He was the one talking about 'teaching the Star Trek Opera.' We managed to get him into a sub-acute facility, but he left after one night. The only contact we've had was [FSP Director] seeing him in his bathrobe near [lake]. We filed a missing person's report and… well…
>
> *MCT Director:* We should close. I always say, 'an open chart is not treatment' (Fieldnotes, 4/15/18).

In other cases, clients simply declared they wanted nothing more to do with the Clinic. As in France, clients floated in and out of care. 30% of new clients had previously been treated in the clinic; of those, three-fifths had come for an intake but never actually connected to treatment in a meaningful way.

Unlike in France, though, those cases were formally closed, keeping the number of people on the Clinic's rolls down. As argued by Lara-Millán (2017:82), the clinic appeared as one among a range of public agencies engaged in "people exchanges," a constant churn through which "discrete institution[s]…abdicate or obtain responsibility for people, caseloads, and often, the public revenue attached to them." But whereas Lara-Millán (2017:82) sees these exchanges as emblematic of a lack of "rationally-coordinated…coherent population management," this constant motion was part of a coherent logic that provided at least some indications of institutional success. If clients were recovered enough to get what they needed outside the public mental health system, so be it. If they reappeared, the Clinic had a clear set of procedures for encouraging those individuals to get care, modulating it based on the person's service utilization and functional impairment, and withdrawing it anew.

Conclusion: The Logic of Logics

An ethnographic literature on change in medical organizations shows how contemporary medical professionals are buffeted by competing demands to deliver quality care at limited costs in line with external requirements for documentation and evaluation (Cain 2019; McPherson and Sauder 2013). Professionals in mental health care, in particular, seem to be particularly torn between their commitments to patients and their obligations to funders and regulators (Brodwin 2012; Dobransky 2014; Scheid 2004). These portrayals are in line with a literature on "logics" that has gone from talking about society-wide logics of "capitalism" or "Christianity" (Friedland and Alford 1991) to emphasizing the co-existence of multiple and sometimes competing logics on the ground (for a review, Haveman and Gualtieri 2017).

But if logics are supposed to help actors make sense of the world and to know what to do without being forced to engage in a "cognitively overwhelming" process of "conscious reevaluat[ion]" of goals and practices for meeting them "on a daily basis" (Vaisey 2009:1684), what role do fragmented and competing "logics" actually perform? I have shown that, for all their frustrations, clinical teams in the U.S. and France act, for the most part, based on a coherent sense of what mental health care should be and to what ends it should be used, a sense they appear to largely share with regulators, policy-makers, and advocates. If ethnography reveals fragmentation, comparative research allows us to piece those fragments back together to show how systems in the two countries are based around "rationalization" and "rationing." These logics had a mirrored relationship with "medicalization"—the other trend, alongside some version of "economization/privatization/rationalization"—most frequently identified in contemporary mental health care. In the U.S., rationalization advanced through the incorporation of mental health care into medical institutions, but also through a cognitive de-medicalization of mental health decision-making and, to an even greater extent, treatment goals.

This chapter further speaks to the literature in medical sociology by asking what *kinds* of categories are used in decision-making in the two countries. We have long presumed that, in an era of medicalization, "the diagnosis determines the institutional fate" (Castel 1988:150) of the severely mentally ill. The Diagnostic and Statistics Manual, in particular, appears as a "rationalizing force" (Brown and Cooksey 1989:1135) by reducing the mentally ill to clusters of symptoms and by homogenizing practices across countries (see Horwitz 2001; Lakoff 2006). But while diagnosis figured into allocating care in both countries, it was determinative in neither. In France, clinicians oriented themselves less to what clients *had* but who they *were*: real *malades,* people with *troubles psychiques,* or persons who were above all addicts or just dysfunctional. In the U.S., what people were suffering from was far less important than what they were doing (in terms of service utilization) and what they were capable of doing (in navigating a fragmented safety net). In fact, for the U.S., I have shown how redefining the criteria for and goals of mental health care in terms of behaviors—something evident in the relabeling of some state "mental health" departments as "behavioral health" ones (Backlar 1996; Hudson 2018)—was a key move in facilitating rationalization. While such "behaviorism" certainly has a long history in American culture, this shift really is new: in the early days of community mental health, clinicians were just as focused on subjectivity and psychoanalysis as the French (Dinitz and Beran 1971; Meyer 1985), thus immunizing it from rationalization.

Mental health presents an intriguing case for the literature on rationalization and economization in medicine writ large. "Rationalization" in both countries certainly could not be reduced to "privatization" or even "commoditization." Even in the U.S., while managed care companies were certainly profit-making entities, that the state would ultimately pay and that those dollars would flow down to mostly non-profit or public clinics was never in doubt. Sparing mental health care is perhaps even harder because, unlike the high-users of services studied by Livne (2019), most mental health clients are not dying in any immediate sense. The moral work of why public mental health care delivered to chronically ill persons should be limited is that much more complex. While previous analyses have presented the American mode of healthcare rationalization as "complex, fragmented, and contradictory" (Hoffman 2012:x) and lacking "central control mechanisms" (Livne 2019:251), rationalization in mental health care in the U.S. depended on the active role of the state—at the federal, state, and city level, as I show—in reconstructing what care actually is. It was in part the moral distance from simple economization and proximity to lofty goals of recovery that made it so compelling.

Critics of managed care are quick to evoke the polluting power of markets and disenchantment brought by rationalization in decrying the way that "mental health has become a commodity" and clinics "businesses…providing a low-cost service" to "consumers" (Scheid 2004:74). By looking comparatively, though, we can analyze the impacts of rationalization not relative to some idealized past of abundance and easy access, but to the very real practices in which clinicians must engage in rationalization's absence. The French *secteurs* may have insulated themselves from evidence-based evaluations and spurned conscription into expansive public health projects, but this did not protect them from constricted budgets and increased demand. Their response through a logic of rationing created its own set of exclusions. For example, while in the U.S. clinicians vocalized their concern that their focus on behaviors meant they under-served women, the CMP arguably under-served men whose "gendered cultural scripts" (Hill and Needham 2013:85) dictated they express their distress through addiction or anti-social behavior. The logic of logics is that they provide an intelligible, often automatic way to orient action; they largely hide the exclusions they generate.

If these findings show the value of comparative research, they also should give pause for those seeking to make comparisons in terms of aggregate statistics on services delivered or diagnoses treated. In France, the public system seemed to serve an ever-rising share of the population, but my ethnographic observations show just how many of these data points were receiving minimal care or simply lingering administratively because, on principle, the *secteur* did not close dossiers. And if the U.S. has been more successful in stepping people down and into the private system, a striking proportion of closures happened because people simply disappeared, a fact that was less distressing to clinicians because they knew they would be back anyway. Medicalization in the U.S., as measured by an ever-expanding pile up of diagnoses, implies that patients are receiving bio-medical treatments even though they might not be. In a world of triumphant bio-medicine and inexorable marketization, the fact that French and American mental health professionals see themselves as similarly beleaguered is unsurprising; the extent to which culture continues to serve as a bulwark against convergence is perhaps more notable.

Chapter 2: Bureaucratically Split Personalities: (Re)ordering the Mentally Disordered in the French State

In the government offices responsible for granting benefits and services to people with disabilities in France, people with severe mental disorders pose a continual classificatory challenge. Looking at the dossier of a 26-year-old man with schizophrenia, one evaluator remarked, "His medical certificate [written by a psychiatrist] says he has severe symptoms, but on the next page, it's written that he's 'autonomous in his activities of daily life'"—the latter being the primary basis for a disability determination. "In any case," another evaluator points out, "the certificate is old. He's probably psychotic again by now. We can't refer him for professional retraining if he's not stable." A final evaluator sighed, "He probably needs help with housing, but for some reason, he has crossed out all those boxes on his application." Here, an individual whom everyone agreed was severely "mentally ill" was not recognized as "disabled," despite the benefits in terms of housing, employment supports, and aid in daily life such a dual designation would bring.

These lower-level bureaucrats were attempting to apply the official classifications of the state, whose centrality in the "certification [and] consecration [of] legitimate classifications" has attracted growing sociological attention (Fourcade 2009:259; see, also, Bourdieu 2015; Loveman 2014; Norton 2014). A rich literature on "classification struggles" (Barman 2013; Goldberg 2005; Strand 2011) has analyzed how conflicts over jurisdictions and flows of resources can create barriers to the implementation of official classification schemes like this one. In this chapter, however, I show how, even without overt conflict, the attempt to combine populations administered by different wings of the state can create a "bureaucratically split personality." A bureaucratically split personality is a classification that implies that the same people belong to multiple categories which entail inconsistent behavioral expectations, principles of expert evaluation, and institutional trajectories. This makes these schemes bureaucratically unworkable and unstable.

Until 2005, the French state directed people with intellectual or physical limitations and those with mental illnesses into separate institutions, run by different sets of professionals, under the aegis of different bureaucracies. In 2005, however, the state anointed a new classification, "psychic handicap."[1] It established that a "substantial, durable, or definitive alteration of…psychic functions"[2] caused by mental illness could create a "restriction of activity or of life in society" and thus constitute a "disability." According to the President of the country's organization for the families of people with mental disorders (UNAFAM), this transformation was "truly revolutionary" (Interview, 7/20/16). People with severe mental disorders would continue to receive care from the public psychiatric system but also be incorporated into the state's broader attempt to make people with disabilities into empowered actors capable of managing an autonomous "life project" (see Power, Lord, and DeFranco 2014). Psychic handicap thus looked like a case of the dramatic shift in "biographical trajectory, memberships, or location" created when a new classification enters the "process of making people" in state institutions (Bowker and Star 1999:223).

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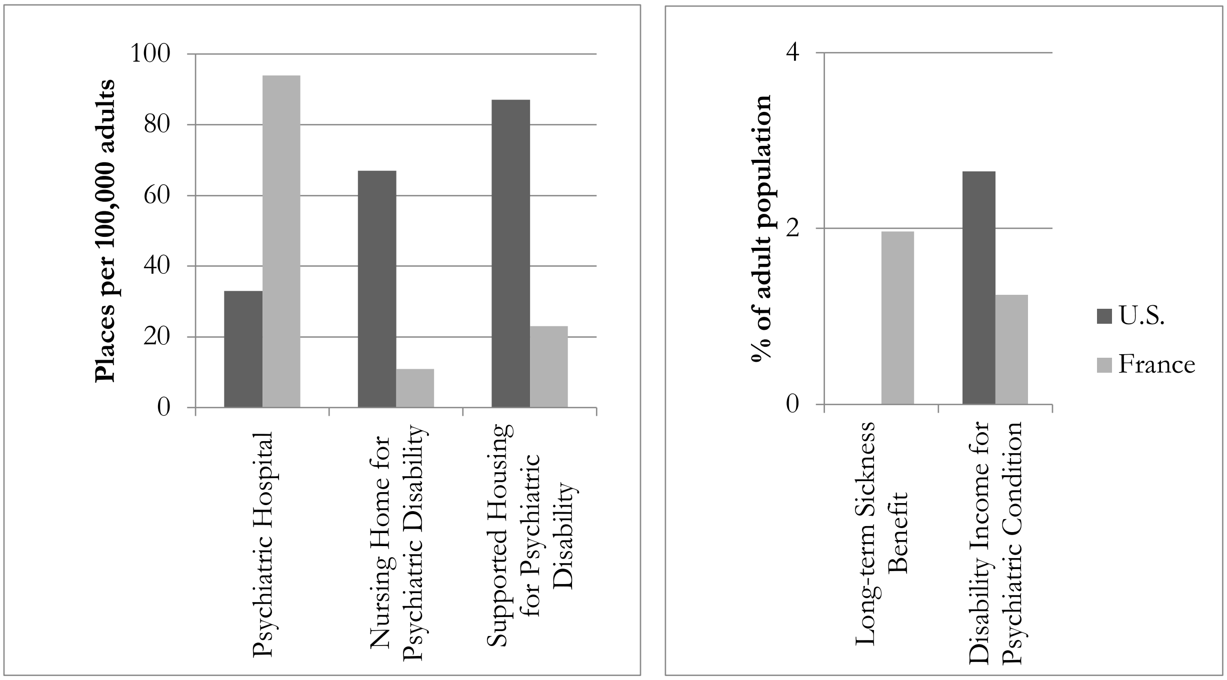
[1] "*Handicap*" in French can be translated as either "disability" or "handicap." For clarity, I use "psychic handicap" ("*handicap psychique*") to refer to the specific category advanced by advocates for people with mental disorders and "disabled" to refer to the broader administrative classification that could contain people with "physical" "mental" or "psychic" handicaps.

[2] République Française, *Loi n°2005-102*.

Figure 2.1: Medical and disability services for people with mental disorders in France and the United States



Sources: OECD Health Statistics; Davis et al. (2012); Direction de la recherche, des études, de l'évaluation et des statistiques. 2013. *Les Établissements et Services Pour Adultes Handicapés*. Paris, France.

As the opening anecdote suggests, "psychic handicap" represents a case where a new classification scheme does not achieve its intended effect. Ten years after its codification in public policy, key actors were moving away from psychic handicap as a lever for radically changing the state's response to people with severe mental disorders. They were instead proposing ways to advance individual autonomy and recovery without a designation of psychic handicap.[3] Compared to the United States, where the idea that "mental illness" causes "mental disability" has long been recognized,[4] people with mental disorders in France remain primarily in services and institutions that serve people with "illness" (not "disability") and under the jurisdiction of psychiatrists (Figure 2.2). This outcome is puzzling. The introduction of psychic handicap had the support of the upper administration and acquiescence of psychiatry, and thus avoided the overt struggles that have frequently accompanied changes in the classification of the mentally ill (Abbott 1988; Goldstein 1987; Strand 2011). Moreover, the new classification scheme had the cooperation of the "street-level bureaucrats" (Lipsky 2010; Prottas 1979; Watkins-Hayes 2009) responsible for helping people with mental disorders apply for benefits, for evaluating those applications, and for ensuring their entrance into disability institutions. In explaining the trajectory of psychic handicap as an instance of a bureaucratically split personality, I shift from analyzing struggles over the elaboration and use of a single category to contradictions created when multiple classifications are supposed to be applied to the same people.

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[3] This shift is visible in the national ministerial strategy, which talks more about "avoiding" psychic handicap than giving benefits based on it. Secrétariat d'État chargé des personnes handicapées. 2016. *Stratégie quinquennale de l'évolution de l'offre médico-social: Volet handicap psychique*. Paris, France. Some other examples I encountered during my fieldwork included "Chez Soi d'Abord," Clubhouse France, SAMSAH-Prepsy, and Job Coaching.

[4] Comptroller General, *Returning the Mentally Disabled to the Community*.

I start this chapter by outlining the parallel development of France's system for the "mentally ill" and "disabled" and how the introduction of the category "psychic handicap" in 2005 was intended to allow the severely mentally disordered to be both. I demonstrate the apparent absence of a classification struggle between social movements, key professions, and the state. The second empirical section analyzes, in turn, how psychic handicap emerged as a bureaucratically split personality in the process of applying for its recognition, its bureaucratic evaluation, and its integration into disability services and institutions. At each stage, incongruities between the expected passivity and activity of people with mental disorders, the subjective or objective character of their troubles, and the variability or stability of the limitations made the notion of psychic handicap practically incoherent. Through three mechanisms, *refractory looping*, *outsourcing expertise*, and *classification by default,* these contradictions resulted in the return of responsibility for people with mental disorders to the health system, where they had a single bureaucratic identity as "mentally ill."

In the conclusion, I reflect on why combining mental illness and disability was a bureaucratically split personality in France when the two are readily used in tandem in the United States. I argue that the difference stems not from the professional or bureaucratic competition typically evoked in the literature on classification struggles, but from the differing meanings of illness and disability is each context and the tools classifiers had to apply them. This notion of bureaucratically split personalities can thus be used to expand our understanding of the conditions that shape how official state classification schemes enter bureaucratic practice and reshape the definition of populations, resulting in profoundly different and consequential distributions of populations across state institutions.

Theoretical Framework

Classification Struggles and Bureaucratically Split Personalities

Modern states govern their populations through applying a dizzying and expanding range of classifications (Bourdieu 2015; Foucault 1991; Morgan and Orloff 2017). Because classifications are not just about making sense of the world, but also "sites of power relationships [and] political action" (Friese 2010:148), new state classifications are frequently marked by struggles over which categories are recognized as legitimate, who gets to apply them, and what resources and benefits derive from them (Barman 2013; Goldberg 2005; Mora 2014). The history of psychiatry is riven with such struggles. Early psychiatrists competed with priests and judges over whether the mentally disordered were "ill" versus criminally dangerous or morally deviant (Abbott 1988; Goldstein 1987). More recently, classification struggles in the U.S. have centered on whether jurisdiction over the mentally ill belongs to psychiatrists, social workers, or psychologists (Bosk 2013; Craciun 2016; Strand 2011). In analyzing the introduction of psychic handicap, this literature would call attention to potential conflicts between medical and disability professionals around the new shared jurisdiction over the mentally disordered it implied.

Classification struggles are not limited to the upper echelons of the state, where new classifications are elaborated and official criteria for their application defined. A separate literature has looked at classifications as deployed by "street-level bureaucrats": public servants who are in direct contact with citizens and who, while nominally bound by sanctioned categories, have significant discretion in how those categories are used and in allocating resources attached to them (Lipsky 2010; Prottas 1979). For instance, scholars have analyzed how bureaucratic resistance to a changed mandate and a new professional identity slowed welfare reform's efforts to transform benefit "recipients" into "workers" (Dubois 2003; Sandfort 2000; Watkins-Hayes 2009). Similar analyses of intra-organizational processes in healthcare institutions confirm that "even the most dramatic change at the macro level comes to nothing if it is not collective embraced in practice by those who must do their work in a new way" (Kellogg 2011:7).

This chapter examines the trajectory of a new state category from a different angle, emphasizing not struggles over a single classification but contradictions between them. It focuses on cases where a new classification is intended to serve as a bridge through which previously mutually exclusive classifications come to apply to the same people. The recognition of the autism spectrum, for example, has enabled some children once called "mentally retarded" and placed in specialized institutions to receive benefits on the basis of "disability" *and* access mainstream educational services as "students" (Eyal 2013). In this respect, autism functioned as what Star and Griesemer (1989:409) call a "boundary object," which "lives in multiple social worlds" and facilitates cooperation between them. A classification like the autism spectrum serves as a boundary object because it is flexible enough to be used by multiple communities (educators, psychologists, or autistic people themselves) without unilaterally imposing one group's understanding of that object on the others (Bowker and Star 1999:297). Psychic handicap was, in France, an attempt to create a similar boundary object that would bridge the previously mutually exclusive worlds of mental illness and disability.

In practice, however, psychic handicap was a *bureaucratically split personality*: an attempt to combine classifications that were irreconcilable without a fundamental alteration to one or the other. Each term in "bureaucratically split personalities" captures part of my approach. I use "bureaucratically" to differentiate from a literature that emphasizes the "symbolic constraints" to policymaking (Mayrl and Quinn 2016:2; see, also, Norton 2014; Steensland 2006). These constraints render some classificatory combinations—like a fusion between "deserving" workers and "undeserving" poor in the U.S.—"unthinkable" (Mohr and Duquenne 1997:355). But bureaucratically split personalities are not so much "unthinkable" at the level of policymaking but rather "unworkable." Actors may be in agreement over what classifications should be used and how, but they may struggle to adapt existing tools and procedures in ways that allow them to integrate them into organizational processes.

Second, I refer to "splits" to emphasize that bureaucratically split personalities stem from institutional divisions between the "many hands" of the state (Joyce and Mukerji 2017; Morgan and Orloff 2017). Different agencies develop distinctive practices for applying categories, expectations for those they classify, and processes for allocating resources based on those classifications. Mol (2002:119, 138) points to how such radically different visions (in her case, of patients and of pathologies) can co-exist in a single organization so long as these worlds are "kept apart" and boundary objects remain "fuzzy" enough to allow cooperation without standardization. This chapter, however, examines situations where the meaning of psychic handicap needed to be precisely defined and applied; in these moments, the distinctive visions of and expectations for the "mentally ill" and "disabled" developed by different wings of the French state snapped into sharp relief. Such moments may create a process of "splitting" by which previously latent "perceived gaps" between classifications "widen," "thereby reinforcing [the] mental separateness" (Zerubavel 1996:424) of populations that a new classification was supposed to bring together.[5]

Finally, I use the term "personalities" to highlight that bureaucratic splits are most likely to be problematic when classifications imply that one is a certain *kind* of person. Hacking (1995:352, 360) describes "human kinds" as population groups about which experts claim "systematic, general, and accurate knowledge" that provides "principles through which [to] interfere, intervene, and improve." A child can carry multiple psychiatric diagnoses—like "oppositional defiant disorder" and "ADHD"—without any contradiction. Both place them within a single human kind, "mentally ill," and imply a common set of interventions. But, as Eyal (2013) shows, diagnoses of "autism" and "mental retardation" are profoundly incompatible, because they imply different life trajectories,

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[5] Maryl and Quinn (2016:5) refer to this as "boundary activation" (see Lamont and Molnár 2002).

principles of expert intervention, and institutional homes. Incompatibilities such as these, which are characteristic of classification schemes that I am characterizing as bureaucratically split personalities, are not easily reconciled with simple changes to diagnostic criteria or classification procedures.

Bureaucratically Split Personalities in Practice

Bureaucratically split personalities emerge when the introduction of a new classification, which would bring together populations administered by different wings of the state, reveals incongruities and incompatibilities between them. These contradictions are not at the level of abstract conceptualization, but the concrete process of putting a new classification into bureaucratic practice and using it to shift the way a population engages with state institutions. In this section, I consider what differentiates a new state classification that serves as a boundary object from one that becomes a bureaucratically split personality. I consider literatures that analyze *applying* to be classified, *evaluating* eligibility for a classification, and *institutionalizing* that classification into organizational processes. I identify three mechanism—*refractory looping, outsourcing expertise,* and *classification by default*—to explain how state agents resolve the contradictions created by a bureaucratically split personality.

Applying – State classifications vary in the extent to which they can be unilaterally imposed: states can conscript "soldiers" but generally not "patients." Classifications that require some cooperation, then, must contend with what Hacking (1998:21) calls "looping." People "tend to conform to or grow into the ways they are described" in administrative or professional classification schemes, but this in part because they themselves act in ways that change those categories. Paradoxically, this dynamic engagement of people with categories constructed by the state actually makes those categories seem more natural and entrenched, as when racial classifications added to censuses became the basis for political mobilization in Latin America (Loveman 2014).

That populations might "loop" with respect to multiple classifications simultaneously is latent but not explicitly analyzed in existing studies. Hacking (1998) shows how the way women responded to talk therapy but not medication seemed to confirm that they had Multiple Personality Disorders—which meant that they were *not* schizophrenic, as many were previously diagnosed. I call *refractory looping* the process by which a population "growing into" one category implies them "growing out" of another.[6] As I show, psychic handicap implied contradictory expectations for the way people would apply for benefits and engage with professionals. Over time, psychic handicap changed in a way that made in more synonymous with mentally ill *and* clarified the meaning of disability in a way that increasingly excluded the mentally disordered.

Evaluating – A new classification scheme has little meaning unless some bureaucratic agency or professional group accepts jurisdiction for assigning it (Barman 2013; Kellogg 2014; Mora 2014). As Porter (1996) shows, the jurisdiction granted by states to bureaucrats increasingly comes with the expectation of "objectivity"; that is, the reliable application of rules to create decisions that appear impersonal, reliable, and publicly defensible (see, also, Bracci and Llewellyn 2012; Sandfort 2000). Psychiatrists, for instance, have responded to challenges to their jurisdiction by adopting new tools, criteria, and symptom scales intended to show the scientific basis of diagnosis (Horwitz 2001; Strand 2011; Whooley 2016). This chapter analyzes how the professionals evaluating psychic handicap were supposed to "link together" (Eyal 2013:864) a set of information about mental illness in a person's application and their tools for objectifying disability in order to perform an expert evaluation (see,

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[6] Navon and Eyal (2016:1428) describe how looping with respect to autism "disabled" other interpretations of children's condition. This terminology would be confusing in this chapter, and those authors' use of the term does not consider competing classifications *per se*.

also, Berg and Bowker 1997; Mol 2002). Psychic handicap was a bureaucratically split personality insofar as these two were a poor match for one another.

Evaluators did not, however, respond by "burden shifting" (Seim 2017) responsibility for psychic handicap onto other agencies or "rubber stamp" (Lipsky 2010:130; Prottas 1979:68) psychiatric evaluations as their own, as the literature on classification struggles in bureaucracy suggests. Instead they *outsourced expertise*: incorporating measures that were not supposed to be part of their evaluation and thus collapsing one classification into another rather than linking them through a boundary object. Showalter (2019) shows a similar process in how early 20th century psychiatrists in New York prisons defined "psychopaths" using behavioral criteria produced by the justice system. Outsourcing expertise in this way meant that re-classifying people as psychopaths did little to transform them from being a "criminalized" to a "medicalized" population.

Institutionalizing – The application of a classification by itself has concrete meaning only once it ties those classified individuals into a broader infrastructure that acts upon that label (Bowker and Star 1999:319). Public health surveys that classify many U.S. prisoners as "mentally ill," for example, have little impact so long as inmates remain in prisons without treatment. When the goal of a new classification is to help the classified population enter into pre-existing institutions, then, the task is one of "commensuration": showing that new individuals are comparable to existing ones along some common relevant metric (Espeland and Stevens 1998; Lakoff 2005; Lamont and Molnár 2002). One such case was the use of I.Q. by parents to claim that their "learning disabled" children were close enough to "normal" to enter schools in the U.S.; the lack of a common measure in Germany left similar individuals in segregated institutions (Powell 2010).

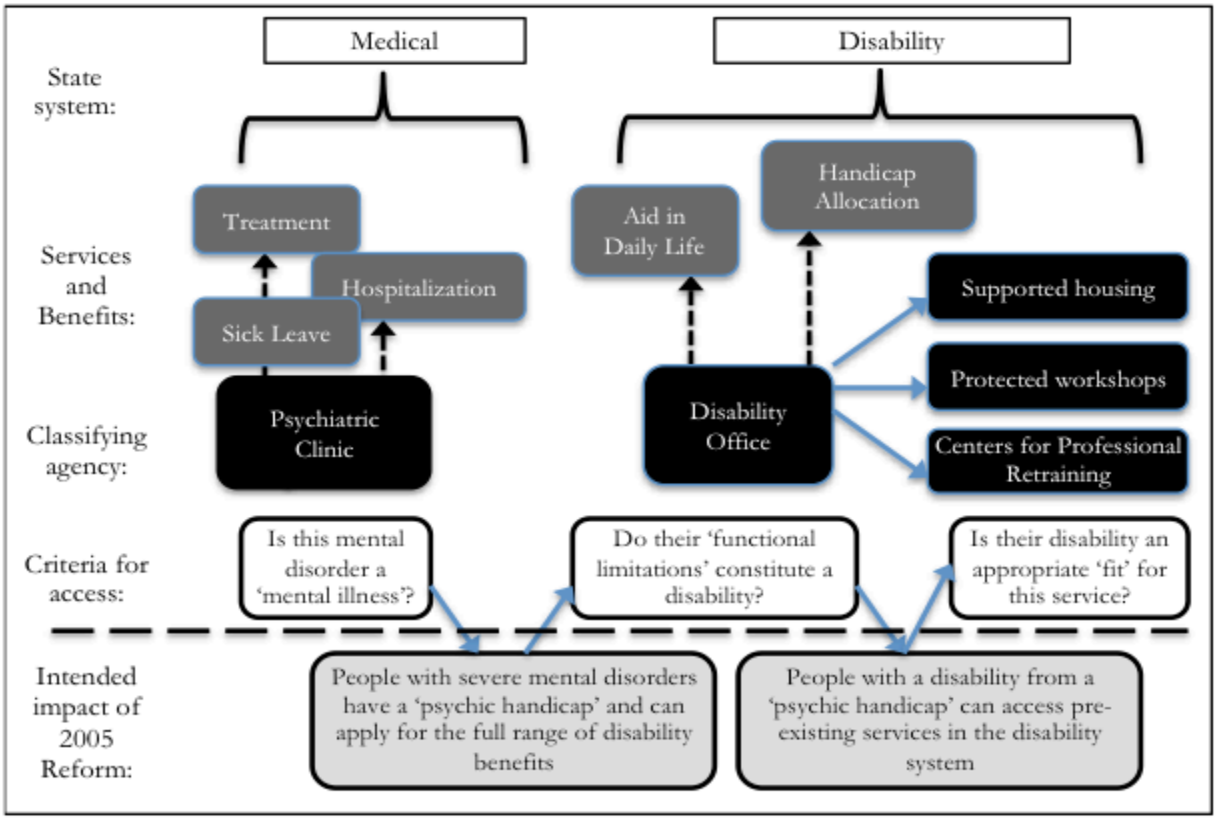
A boundary object implies that a person has characteristics commensurate with the populations served by multiple sets of state institutions. When contradictions in these expectations emerge and a bureaucracy rejects someone as "incommensurate," that person does not necessarily disappear into a classificatory vacuum. They instead tend to fall back into programs with more flexible criteria, which I call *classification by default*. In the U.S., people who do not fit the increasingly narrow eligibility criteria for welfare benefits on the basis of being "poor" wind up receiving services from emergency health, disability, or penal institutions that serve broader categories of persons (Hansen, Bourgois, and Drucker 2014; Lara-Millán 2014; Seim 2017). This mechanism thus calls attention to how the resolution of bureaucratic "splits" depends on the mix between universal and targeted programs in different wings of the state.

Bureaucratically split personalities do not end in the decisive outcome of a classification struggle. Rather, as a new classification scheme is applied, evaluated, and institutionalized, contradictions within that scheme can lead to *refractory looping, outsourcing expertise,* and *classification by default* that limit that scheme's impact and gradually undermine its continued use.

Data and Methods

Data for this chapter were collected as part of a broader project on public institutions tasked with managing people with severe mental disorders in Paris, France. Through preliminary interviews and documents, I identified key sites in the health and disability sectors where the consequential bureaucratic classificatory decisions in the lives of people with mental disorders are made (see Figure 2.2). This process frequently started in a Medical Psychological Center ("*Centre médico psychologique,*" hereafter "Psychiatric Clinic"). Over the course of seven months in 2016, I observed weekly triage meetings in which nurses would present new cases to psychiatrists, who would determine who had access to psychiatric care. I also attended discussions between nurses, psychiatrists, and social workers of difficult cases who might apply to be recognized as disabled based on having a psychic handicap.All applications for disability benefits are then processed by a multi-disciplinary team of

Figure 2.2: The French health and disability systems and intended impact of the 2005 reform



generalist doctors, psychologists, and social workers in a Departmental Home for Disabled Persons ("*Maison départementale des personnes handicapées,*" hereafter "Disability Office"). I spent six months (also in 2016) observing evaluations of new demands, meetings to discuss employment of disabled persons, and sessions of the departmental commission responsible for making final determinations on complex cases and appeals.[7] The Disability Office would then orient applications towards service providers for professional insertion, protected work, aid in daily life, or long-term housing, with whom I conducted interviews and site visits.[8]

In these settings, collective decisions are made outside of the presence of the applicants; the primary research subjects of this project were professionals, not patients/clients. I avoided recording any potentially identifiable information on the latter. I show how people with mental disorders engaged with the category of psychic handicap through looking at bureaucratic traces and reports of their behavior, rather than direct interviews with them.[9]

I contextualized my observational data from the Clinic and Disability Office through 186 qualitative interviews with professionals and policymakers. Among interviewees, 38 were involved in direct service provision in the health sector and 47 in the disability sector; questions focused on

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[7] I also obtained unpublished statistics from the Disability Office, which show that the classification decisions I directly observed were representative of the broader range of demands treated by the Disability Office and their outcomes.

[8] Direct observation of decision-making over access to downstream services for housing and employment was not practical, because many structures (such as a fifty-bed nursing home) would only admit one or two new people per year.

[9] This focus on observable responses to a classification rather than phenomenological experiences of being classified is consistent with other studies on "looping" (Eyal 2013; Navon and Eyal 2016).

classificatory decision-making and their appropriation of official regulations and tools. I conducted interviews on the production of these regulations and tools with 25 people involved in public policies for health and 24 in disability. This included nearly all the key figures in the relevant national ministries who worked specifically on mental illness or psychic handicap, as well as those with the same responsibilities in regional and departmental agencies around Paris. The remainder were representatives of key advocacy organizations, professional groups (such as the psychiatrists' unions), research institutes, and the legal sector. Among the total, 50 were trained as psychiatrists, 39 as nurses or psychologists, 21 as social workers or special educators, 17 as generalist or public health doctors, 17 as lawyers, and 31 as administrators.[10] I also examined official government reports, directives, classification scales and other tools, unpublished policy evaluations, and the archives of the Ministry of Health.

I developed a coding scheme iteratively, starting by differentiating the various kinds of demands faced by the Psychiatric Clinic and Disability Office, then considering the range of possible responses to those requests, and subsequently developing categories that captured the reasoning professionals used to justify those decisions. I focused on 296 decisions at the Disability Office where decisions were made over the allocation of benefits or services, in particular the 206 cases in which someone did *not* receive at least one of the benefits for which they applied.

Paris is undoubtedly a distinctive case within France. It is also the place where the introduction of psychic handicap would be most likely to succeed. The key actors that pushed psychic handicap (Ministries and advocacy organizations) are based in Paris. As many informants insisted, actors making classificatory decisions in Paris are thus subject to much greater oversight and scrutiny in their implementation of national policy. Moreover, services in both the disability and health systems are well-funded and widely available, suggesting that the limited impact of psychic handicap on the mentally disordered was not just a question of resources. Interviews and archives, combined with several weeks of comparative observation in a separate Disability Office outside of Paris and a different clinic and hospital, increased my confidence that the patterns I describe are reflective of the general bureaucratic challenge of using psychic handicap in the way policymakers intended.

Broadly, this project follows the extended case method (Burawoy 1998) in which the researcher attempts to understand concrete situations by looking outward to broader structural forces and backwards to the history weighing on those situations. My goal was thus to put theories of classification struggles, street-level bureaucracy, and medical sociology into dialog with my observations. The single case of psychic handicap cannot establish the necessary conditions for the success of a new classification or determine what would happen if a "split personality" appeared at the level of applying categories but not institutionalizing them. My goal, instead, is to elaborate theoretical mechanisms that can be applied and tested in other empirical situations (see Hirschman et al. 2016).

The Politics of Psychic Handicap

Separating Mental Illness and Disability

This section considers the separate development of France's health and disability system and the divergent meanings they attached to "disability" and "mental illness." Any separation between the two, both practically and symbolically, was a relatively recent one. In 1961, at the advent of *sectorisation,* people characterized as senile, mentally retarded, or having "organic" brain disorders

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[10] The remainder, mostly in advocacy organizations, had educational backgrounds not directly related to health, disability, or public policy.

made up forty percent of the hospital population.[11] In 1963, the Ministry issued a new directive, noting that "it is necessary to take a certain number of measures to prevent 'promiscuity' between these subjects [profoundly retarded, senile-demented] and sick people with evolving mental troubles, which require distinct therapies."[12] The decree was clear, though, that the former were still *malades*—"These are severely handicapping illnesses that require close medical oversight and assistance for a long period of time"—and responsibility for them "remain[ed] the responsibility of the psychiatric *secteur*." At a classificatory level, the differences at this point were not particularly sharp: in 1958 the yearly conference of the *Fédération d'aide à la santé mentale–Croix-Marine* (FASM-CM), an important motor in the *sectorisation* movement, centered on the "treatment and assistance of the psychically handicapped in the social milieu."[13]

Psychiatry's domain narrowed significantly in the 1970s. The 1975 Law in Favor of Handicapped Persons brought together two disparate sets of institutions: centers to retrain "invalid workers" and "wounded soldiers" as a matter of national solidarity, and residential schools created by the parents of "deficient children" as a matter of charity (Barral 2007:217–20; Winance, Ville, and Ravaud 2007:165–66). The law, the Health and Social Affairs Minister[14] declared, "created a true social statute" for "disabled persons" (qtd. in Chapireau 2016:5) as a new, state-recognized kind of person. These disabled persons, marked by an irreparable incapacity to live independently or work in ordinary settings, would receive non-medical interventions from protected workshops, supported housing, and services for aid and accompaniment in daily life. The law drove the removal of people with intellectual disabilities and the dependent aged from psychiatric hospitals.

The reform sparked a classification struggle over whether the "mentally ill" could also be "disabled." As the literature on professions and jurisdictional conflicts would predict (Abbott 1988), the psychiatrists' unions feared that relabeling people as "handicapped" was a "modality of escaping the expensive designation of being a 'sick person'" (Ayme 2002:185). The conflict highlighted the different meanings of the two categories. The dominant image of a handicapped person was of someone with a clearly-identifiable limitations that would be stable over time. Admitted one psychiatrist active at the time:

> If psychiatrists were hostile to 'handicap', it's in part because it called to mind, at least unconsciously…the 'idiot' of Esquirol [an 19th-century disciple of Pinel]. Because Esquirol said: it's a fixed state, definitive, there's nothing to do, even less for children. And that definition has been attached to handicap…The handicapped is a person who doesn't need care but just needs some help and a bed (Interview, 4/5/16).

This offended the psychoanalytic currents of French psychiatry which saw mental illnesses as having a dynamic temporality, creating a troubled subjectivity that a psychiatrist could identify, treat, and transform (Lanteri-Laura 1972). In the formulation of one psychiatrist active in the main psychiatric union, "handicap as a category = a new wall to break down" (qtd. in Ayme 1995:373).

The opposition of psychiatry took its most concrete form not with the law itself, but with the subsequent decrees specifying how it would be applied. The debate centered on whether social security should pay for long-term housing for *malades mentaux* leaving psychiatric hospitals under the

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[11] François Chapireau, *Unpublished data,* Received through personal communication November 2015.

[12] Ministère de la santé. 1963. *Circulaire du 27 aout 1963 relative aux mesures particulières à prendre, dans le cadre de la lutte contre les maladies mentales, en ce qui concerne les arriérés profonds et les déments séniles*. Paris, France: 2.

[13] Bernard Durand in Fédération d'aide à la santé mentale - Croix-Marine. 2016. "Égalité, citoyenneté et handicap psychique: de la loi du 11 février 2005 à la loi de santé..." *Pratiques en santé mentale* 1(February):1-100.

[14] Both "disability" and "health" are covered by the (frequently renamed) Ministry for Health and Social Affairs, but in separate directions. For simplicity, I speak of the "health" and "disability" ministries.

Table 2.1: Overview of France's health and disability systems

	Health	***Disability***
Dominant Profession	Psychiatrists, Nurses	Administrators, Educators, Psychologists
Organization Type	Public	Private Non-Profit
Funding	Central State, National Insurance	Sub-National Departments, Central State
Access	Universal; all people in a given Psychiatric Clinic's territory (with or without self-identification as "mentally ill")	Targeted; accessible only to applicants who self-identify with and are evaluated as "disabled" by the Disability Office
Key Criterion	"Mental illness" as opposed to "psychological troubles": based on disturbances of thoughts, emotions, or behaviors	Limitations in daily life or participation in society; the life project of a person with disability
Regulating Body	Directorate of Health	Directorate of Social Cohesion
Cost per Day	€900 (Psychiatric Hospital)	€240 (Nursing home)

aegis of the disability system, as UNAFAM wanted. Psychiatrists argued that "we are talking about apartheid, a new ghetto, a new law of 1838!" (Ayme 2002:181). The state sided with psychiatry, concluding that insofar as the law on handicap was a "correction destined…to cover up the holes in the social protection system,"[15] the mentally ill did not need to be included, precisely because they were already protected by the French welfare state on the basis of being "mentally ill." In excluding the mentally ill, the 1978 decree creating nursing homes for disabled persons explained:

> Certainly, a large number of mentally ill take care of by the psychiatric *secteurs* can seem like people incapable of autonomy, but this should not mask the fact that mental troubles are essentially evolving. As a consequence, the mentally ill should remain the charge of the *secteurs,* who are the only ones capable of assuring them the necessary continuity of care and to provoke the modifications of their state that will permit them to acquire a certain autonomy and integrate into society.[16]

As a result, from 1975 France had separate disability and health systems with distinct financing streams and regulatory agencies (Table 2.1). They also had distinct logics of social protection, as the nominally universal health system was juxtaposed against a disability system that required a formal recognition of the disability by the precursor to the Disability Office. Meanwhile, psychiatrists had near-undisputed authority to classify illness and intervene in their lives of the mentally disordered, who would be passive recipients of care that could unilaterally imposed on them.

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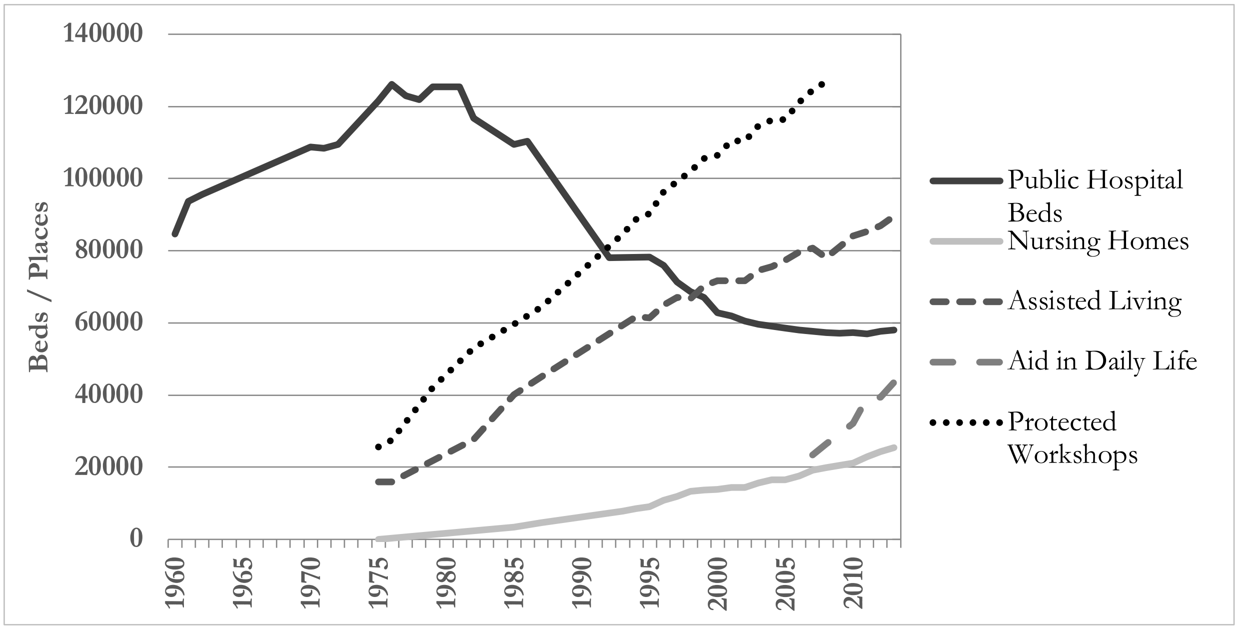
[15] Ministère de la solidarité nationale. 1983. *Bilan de la politique en direction des personnes handicapées.* Paris, France.

[16] Ministère de la santé et de la famille. 1978. *Circulaire du 28 décembre 1978 relative aux modalité d'application de l'art.46 de la loi 75-534 du 30-06-1975 d'orientation en faveur des personnes handicapés.* Paris, France.

Figure 2.3: The Decline in Public Psychiatric Beds and Rise in Dedicated Disability Services in France (1960-2013)



Source: Compiled from *Institut de recherche et de documentation en économie de la santé,* Annual Statistical Yearbooks of France.

Recombining Mental Illness and Disability

Growing budgetary pressures made a revision to this classification scheme seem increasingly necessary in the 1990s. The state began pushing psychiatric teams to abandon activities that did not fit into an increasingly biomedical definition of treatment, such as managing therapeutic apartments or helping patients find work. Moreover, it increasingly identified many psychiatric hospitalizations as "inadequate" because stabilized patients who no longer required intensive medical care stayed for lack of a supported living situation outside.[17] Although like most Western countries France was closing hospital beds by the 1970s, in the 1990s the transfer of funds was particularly stark: the state closed 33,000 beds in psychiatry and opened 30,000 in publicly-funded, privately-run supported housing establishments for the disabled (Figure 2.3). A major 1992 report on the future of psychiatry urged psychiatrists to accept this new reality:

> The reduction of the number of beds and the acceleration of departures [from the hospital] requires attention to the legislation for people with handicaps, which is more open to professional and social insertion that the legislation for psychiatry. The transformation from psychiatry towards social management requires an important modification: 'mental illness' must give way to mental handicap. It's at the cost of this division that the mentally ill can benefit from the law for older people and handicapped adults.[18]

The embrace of the notion of handicap itself, which the report called "onerous," remained cool. Even in 1997, a government report promoting the transfer of psychiatric patients to the medical-

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[17] Direction de l'hospitalisation et de l'organisation des soins. 2008. "Éléments d'analyse des inadéquations de prise en charge en hospitalisation complète." *DGOS 2014 / 011 / 3.*

[18] Massé, *La psychiatrie ouverte,* 234-235.

social sector nonetheless insists a half-dozen times on the distinction between a person who is "mentally ill" and "handicapped."[19]

With no official recognition that mentally ill people could be disabled, however, their access to structures for the handicapped remained limited. The head of one association that was trying to create housing for the severely mentally disordered explained:

> When our association was formed, we were under the umbrella of the health sector. And we went to them and said we wanted to do 'accompaniment' and they said, 'We don't do that, we heal people.' So we went to the department [responsible for disability], and they told us, 'You're talking about mentally ill people. Illness is not our job! Go the health ministry!' (Interview, 6/19/16).

Although medical-social structures created by associations for intellectually disabled children or even those with physical disabilities did accept some people with mental disorders during this time,[20] there were few policy levers to get them to accept more. One functionary who worked in the Directorate of Social Cohesion—charged with overseeing departmental actions around handicap—explained, "they [the mentally ill] had the right to demand allocations [the minimum income for disabled persons], but from an administrative, political, and regulatory point of view, they were not inscribed [in policy] and so we did not have policies targeted at them, there was not lobbying on the part of associations saying, 'What are you doing for us?'" (Interview, 6/16/16). The 2001-2003 Triennial Plan for Handicap, for example, listed 22 million euros for people with autism, 22 million for those with cranial trauma, 18 million for people with severe 'poly-handicaps,' 7 million for the aged—and made no reference to *malades mentaux*.

In 2001, the association of parents of the mentally ill announced in 2001 a desire to "render existent a population" and "make real" that population's rights within the disability system through the recognition of psychic handicap.[21] The organization recognized not only the shift in financing, but strengthening European and international norms that promoted the rights of people with disabilities (Waldschmidt 2009). Thus, when the organization's Vice-President described the initiative as a "demand to make a category of persons that didn't exist before" (Interview, 7/20/16), she meant that the new classification entailed not just new services, but also a new "personality" for the mentally disordered as persons who could be active players in increasingly autonomous lives.

Thanks in part to the organization's lobbying, President Chirac called for public action to "remediate the difficult situation…[of persons] with psychic handicaps, who are currently without any solution."[22] The reference was buried, but UNAFAM nonetheless declared that they "have fought for years for the recognition of psychic handicap. We welcome this presidential declaration with great satisfaction."[23] In the preparation of the law's text, the Assembly criticized that the articles pertaining to the mentally ill in the law of 1975 had not been implemented, an injustice given that "the concerned population represents at least 600,000 people in real difficulty"[24]—a statistic with no

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[19] Joly, *Prévention et soins des maladies mentales*: 33.

[20] For example, in 1996 13.9% of places in *Centres d'aide par le travail* (the predecessors to ESATs) had a "déficience principalement psychique." Piel, Eric and Jean-Luc Roelandt. 2001. *De la psychiatrie vers la santé mentale. Rapport de mission.* Paris, France: Ministre de l'Emploi et de la Solidarité: 20.

[21] UNAFAM. 2001. *Le livre blanc des partenaires de Santé Mentale.* Paris, France: 12.

[22] Chirac, Jacques. 2002. "Discours devant le Conseil national consultatif des personnes handicapées." Paris, France. Retrieved August 19, 2016 (http://discours.vie-publique.fr/).

[23] L'Union nationale des amis et familles des malades mentaux. 2002. "Communiqué de Presse: Le handicap psychique enfin reconnu." *Archives Institut de recherche et de documentation en économie de la santé.*

[24] Chossy, Jean-François. 2004. *Rapport sur le projet de loi pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées.* Paris, France: Assemblée Nationale: 37.

Figure 2.4: Figuring Comparing Medical ("Sanitaire") and Disability ("Médico-Social") Care

Source: FEGAPEI and Fédération hospitalier de France. 2016. *Handicap Psychique: Les 10 Enseignements Clés*. Paris, France.

scientific or epidemiological basis other than that UNAFAM had used it repeatedly. Official recognition of this population was rolled into a 2005 law for the "equality, citizenship, and participation" for the disabled.[25] It recognized that mental illness could create a "disability" insofar as it produced a "restriction of activity or a restriction of life in society" as a result of an alteration of "psychic functions."

Psychic Handicap as Boundary Object

After the 2005 law, UNAFAM changed its name to the "families of sick and/or psychically handicapped people." This suggested their vision of psychic handicap as a boundary object: it allowed the mentally disordered to exist in the bureaucratic worlds of mental illness and disability simultaneously and create "durable cooperation" between each (Bowker and Star 1999:297). One advocate for psychic handicap explained their position at the time: "we don't refuse psychiatry. We know that our family members need psychiatric care…We're not hostile to them." At the same time, though, UNAFAM's Vice-President insisted that "for these citizens" with a psychic handicap, "everything like lodging, activities, professional help—they're going to be accompanied by people not from the health sector. Not psychiatrists, not nurses, but social workers and educators" (Interview, 7/20/16). The idea that psychic handicap portended a new life course was captured in images produced by associations for people with handicaps (see Figure 2.4).

Numerous factors appeared to favor the success of this new classification system in transforming the institutional trajectories of people with mental disorders. The centralized French state appeared to use its power to "produce and canonize…social classifications" (Bourdieu 2015:9; see, also, Carson 2007; Fourcade 2009; Porter 1996) to support this new scheme. The official responsible for implementing the 2005 reform stated that "psychic handicap will be the marker of

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[25] République Française, *Loi n°2005-102*.

whether our disability policies have succeeded"[26] and the President in 2014 declared it a "national priority."[27] A ministerial delegate for handicap insisted, "Clearly, at the level of people with disabilities, today, for the government, a big preoccupation—for the minister and her cabinet—is people with psychic handicaps" (Interview, 7/19/16). While the ministry directorates for disability and health were famous for not communicating, the referent for mental health explained that she had given a directive that the regional health agencies "make sure" appropriate services were delivered to "people with psychic handicaps"

In stark contrast to 1975, medical professionals largely did not "struggle" to prevent the mentally ill from being classified as "disabled." Two major psychiatric professional organizations actually co-signed UNAFAM's original call. One psychiatrist who conducted trainings around the country stated, "We used to hear, 'We're not going to dump our patients in the disability system.' Not anymore" (Interview, 4/15/16). Of fifty psychiatrists I interviewed, only two expressed reluctance to call their patients "psychically handicapped." They accepted that their role was to provide a medical certificate confirming someone's illness, which would accompany a written "life project" and application prepared by the person with the help of a Clinic social worker. The expert determination of eligibility on the basis of a psychic handicap would fall to the Disability Office.

Finally, architects of the law had a vision for how "mental illness" and "disability" could be bridged at a bureaucratic level. Multi-disciplinary teams at the Disability Office would use standardized scales and evaluation tools to translate the mental symptoms characterized by psychiatrists into concrete, functional impairments that constituted psychic handicaps. The Disability Office would then translate psychic handicaps into "limitations in everyday life," which would provide a stable rendering of psychic handicap in a way that made them commensurable with other people with disabilities. Advocates further believed that people with psychic handicaps would themselves be motors in this process, breaking with the passivity historically imposed upon them by the health system. They would thus join other people with disabilities in becoming active participants and self-advocates in applying, being evaluated, and gaining access to disability institutions (Winance et al. 2007).

The law of 2005 did not just introduce a new category, then, but sought to create a new human kind: a "person with a psychic handicap," a boundary object that would allow people to be both disabled and mentally ill. Rather than provoking a classification struggle, this new classification was backed by civil society organizations, professional groups, and the state. A common set of tools and procedures would facilitate coherence and collaboration between disability and psychiatric professionals based on a shared understanding of the limitations and challenges caused by mental disorders (see Star and Griesemer 1989:393).

Psychic Handicap as a Bureaucratically Split Personality

Application: Passive Patients Versus Self-Advocates

The Law of 2005 envisioned that disability benefits would be granted based on the "aspirations of the handicapped person as expressed in their life project,"[28] a document that would be included in their application to the Disability Office. This would be accompanied by a medical certificate from a doctor. As I show in this section, however, the expected active self-advocacy of

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[26] Fédération d'aide à la santé mentale. 2016. "Égalité, citoyenneté et handicap psychique." *Pratiques en santé mentale* 1(February): 84.

[27] Présidence de la République. 2014. *Conférence nationale de handicap: relève des conclusions*. Paris, France: Service de presse. Retrieved June 26, 2016 (http://www.elysee.fr/).

[28] République Française, *Loi n°2005-102*.

disabled persons was in contradiction with the perceived passivity and recalcitrance of people with mental illness.

Most of the most severe patients served by the Psychiatric Clinic arrived through a hospitalization (see Chapter 1). Half of these hospitalizations were legally imposed without the consent of the person, who was deemed unable to recognize his or her own need for care. Social workers and psychiatrists who wanted their patients to receive disability benefits subsequently spent significant time cajoling recalcitrant patients to provide the minimum information necessary to make an application. One psychiatrist described:

> To do a dossier for the [Disability Office], the person needs to be in agreement and for them to be in agreement, they need to be conscious of their handicap. And in fact it's variable with patients, because there are some who are conscious right away that they're not going to get there and that they can't get there, and then others not at all. I have a patient who is twenty-five, it's his second hospitalization in two years, he's had electroshocks, treatments that are very heavy—and he refuses the demand for handicap. And he tells me, several times, 'If I accept, that means I'm sick, that means I'm crazy, and there's nothing left but to die.' So what do you want me to do? For us, there are the criteria, for him, there aren't (Interview, 5/13/16).

I once posited that perhaps manipulative people might come to the Psychiatric Clinic in the hopes of getting a medical certificate that would allow them to get the Handicap Allocation, which at €800 a month is €300 more than France's general minimum income. A social worker brushed me off: "I basically do handicap demands for people who don't think they are handicapped."

My observations of the social workers' weekly meetings at the Clinic confirmed that people often evaded the label of psychic handicap to their obvious detriment. Some patients remained involuntarily hospitalized because they would not apply to a less-restrictive nursing home that only accepted voluntary residents. While scholars have pointed to how fear of stigma can prevent people from applying for benefits to which they are entitled (Hasenfeld, Rafferty, and Zald 1987; Soss 2000), advocates in UNAFAM had presumed—probably correctly—that "handicapped" would be less stigmatizing than "mentally ill" (see Liu, King, and Bearman 2010:1393). What they missed was that "mentally ill" could be imposed on a person regardless of the stigma attached to it, while "psychic handicap" required a degree of cooperation and acceptance that was frequently lacking.

Even when patients were willing to support an application, they did not engage with the category of psychic handicap in a way congruent with the model personality of a person with disabilities—that is, someone who understood his or her limitations and would help identify the supports needed to advance a life project. As one social worker laughed, "People don't give a shit!—for them, it's completely paralyzing to ask them what their 'life project' is. Often it's, 'survive with 800 euros a month' and so we just leave it blank. What's the point of writing, 'Be in care and eat' as a 'project'?" Another averred, "Their social demands are often not very linked with the state where they are. Some tell me, 'I'm ready to live alone, I can manage without psychiatry, I'm doing very well, thank you very much.'"

Psychiatric Clinic professionals' interactions with the Disability Office highlighted how the professionals expected very different behaviors from the same people, even when a shared recognition that they were dealing with the psychically handicapped should have served as a boundary object. One Disability Office official described, "Once, we actually did a visit to the home of someone whose application said she was 'autonomous in everything, handles eating fine, everything is fine, she just needs a little income' and we discovered that all she ate—breakfast, lunch, and dinner—were cans of sauerkraut." This behavior, she noted, was congruent with "mental illness" but not "disability": "For the nurse from the Psychiatric Clinic, that was fine—'at least she's eating!'—but for us, it was like, 'maybe this person could use some help making better choices.'"

Table 2.2: Reasons for rejection from at least one disability benefit

	Mental Disorder (n=59)	***Other (n=147)***
Administrative Ineligibility (Working, Migration Status)	6.7% (4)	22.4% (33)
Benefits De-Motivating	3.4% (2)	4.8% (7)
Incomplete Evidence of Handicap	23.7% (14)	19.0% (28)
Not in Treatment	13.6% (8)	4.8% (7)
Not Sufficiently Handicapped	5.1% (3)	35.4% (52)
Still in Treatment	39.0% (23)	4.1% (6)
Too Handicapped	1.7% (1)	6.8% (10)

The 2005 law envisioned that, after participating in the preparation of an application, an applicant's involvement would continue as they provided more information as needed by the Disability Office. As one official in the Ministry explained, "What has really changed [with the law of 2005] is that our evaluations are participative. The person is at the center, and we do everything as a function of their life-project" (Interview, 7/19/16). Yet even when convinced to apply, people recently released from the hospital would still come to information-gathering interviews at the Office and declare "all is well." The head of the National Federation of Patients in Psychiatry told me that many of her compatriots engaged with "psychic handicap" in a manner that broke with the version of self-awareness expected by disability evaluators: "When we have a meeting at the Disability Office, we're going to wash up, put on a tie, and say, 'I can do everything' and the evaluator is never going to ask, 'Is he saying this just to show he's still human, or because it's really true?'" (Interview, 5/10/16).

When the time came to create a "personalized plan of compensation" on the basis of the life project and medical certificate, the Disability Office was only allowed to make decisions on the specific benefits and services that the person had asked for, not what they thought might be most appropriate. In the case of a 32-year-old man diagnosed with severe bipolar disorder, the head of the Professional Insertion Team asked, "Concretely, is this someone who can work in a regular company?" The person who had reviewed the dossier replied quickly, "No way. But he crossed out the box for a protected workshop." "And," added a psychologist who had interviewed him, "It's a waste of time to even mention it to him." Indeed, in 19 of the 77 cases of people with severe mental disorders that I saw adjudicated in the Disability Office, reference was made to either the person being in "denial" or having an "inadapted" life project (Table 2.2). The latter might refer to someone with behavioral issues or a history of hospitalizations asking to live in a facility with the elderly or a person on numerous anti-psychotics requesting to operate heavy machinery.

Another innovation of the Law of 2005 was the opportunity to appeal a denial of benefits before a twenty-five-member departmental commission that included representatives of disability associations. Yet in over 50 cases that I observed over three months heard by the commission, there was not one in-person appearance from a person who was identified as potentially having primarily a psychic handicap. One psychiatrist commented on how testifying in front of a group of strangers largely excluded the population with which he worked: "to have access to the system you have to know how to manage your relationships. It's like if you say to someone with no legs, 'To go to the Disability Office, you need to do a 110-meter hurdle course!'" (Interview, 2/29/16). This unwillingness to self-advocate made them a further mismatch for the dominant model of a disabled person.

As theories of "looping" suggest (Hacking 1995; Loveman 2014; Navon and Eyal 2016), the various ways that people with severe mental disorders did (or did not!) engage with the category of psychic handicap altered its meaning. Two guides on working with and evaluating people with psychic handicap published in 2016 and 2017 noted an "absence of a demand"[29] and "lack of consciousness of needs"[30] as key components of psychic handicap. Hypothetically, the disability system as a whole could be changed to account for this, allowing for legally mandating people with mental disorders to be evaluated by the Disability Office or to live in disability institutions like nursing homes (as is possible in the U.S.—see Chapter 3). But doing so would directly contradict the work of associations of handicapped persons to differentiate the disability system from the health one: as one proudly stated, in France "care without consent exists, but not [disability] compensation without consent."[31]

The result of the growing awareness that psychic handicap was a bureaucratically split personality that expected people with mental disorders to be both active and aware but also passive or delusional was a kind of refractory looping. Psychic handicap was redefined as more and more a synonym of "mentally illness" and further from "disabled." Even when psychiatrists couldn't see it, social workers in the Clinic recognized how the Disability Office had come to expect not just people who self-advocated, but people who accurately understood their limitations and asked for the "right" benefits. This excluded their clients. As one social worker laughed, "Oh, here's a good one—they [the psychiatrist] wants us to send a new application for [patient name]. Do they remember that she was banned from the Disability Office for threatening an evaluator who told her she was disabled?"

While peoples' refusal to self-label as disabled was clearly partly a function of the lack of "insight" endemic to severe mental illnesses (see Gong 2017), it also reflected that the French welfare state gave this population an option for survival outside the disability system. The head of the program for Minimum Solidarity Revenue in Paris, available to all legal residents below a certain income, complained that she had "thousands" of mentally-disordered beneficiaries who could potentially receive the Handicap Allocation—and in so doing receive several hundred more euros per month—but who were "in denial of their pathology" (Interview, 3/30/16). Another woman, now working in the ministry responsible for the disabled, admitted:

> I was a director of establishments for 10 years in the social sector. One of them was for the homeless, and of course, one-third of the homeless have *troubles psychiques*. And I find it a bit paradoxical that the disability system is better funded than the social sector, because for psychic handicap it's not well adapted, because you often need many years of work to get someone to accept the malady and then to accept the handicap that comes from it. So

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[29] L'agence nationale de l'évaluation et de la qualité des établissements et services médico-sociaux. 2016. *Spécificités de l'accompagnement des adultes handicapés psychiques*. Paris, France: 27.

[30] Caisse nationale de solidarité pour l'autonomie. 2017. *Troubles psychiques: Guide d'appui pour l'élaboration de réponses aux besoins des personnes vivant avec des troubles psychiques*. Paris, France: 16.

[31] Caisse nationale de solidarité pour l'autonomie. 2009. *Handicaps d'origine psychique: Une évaluation partagée pour mieux accompagner les parcours des personnes*. Paris, France: 64.

> someone who is very sick, who has serious troubles, they're not going to be able to do a dossier for the [Disability Office] (Interview, 9/1/16).

These differences speak to how states attach different expectations to official classifications, with some requiring affirmative identification with a category and others capturing those left behind.

Meanwhile, associations developing innovative programs to encourage employment and provide housing for the mentally disordered were "looking for ways to promote access without an application to the Disability Office," as one director explained (Interview, 2/24/16). The struggle from UNAFAM to recognize that mental illness could create a psychic handicap was still won—many of these programs used the term[32]—but people would access these programs from within the health system on the direct recommendation of psychiatrists. The next section considers how, even for the applications that were made to the Disability Office, "psychic handicap" became further detached from "disability" and the aspiration that it would serve as a boundary object between two worlds of welfare in equal partnership.

Evaluation: Subjective Symptoms Versus Objective Limitations

Previous research on France's Disability Offices has shown how they struggle with the classic challenges of street-level bureaucracies: a seemingly-impossible mandate to offer individualized evaluations, despite limited personnel and time, in the face of an avalanche of demands (Baudot and Revillard 2015; Bertrand, Caradec, and Eideliman 2014; Bureau et al. 2013). In my observations, the mix of generalist doctors, psychologists, and special educators there did not abdicate their role in evaluating psychic handicap through directly "burden shifting" responsibility back onto the health system. At one training at the Disability Office, new evaluators eagerly asked questions about the meaning of psychic handicap and nearly half the time was spent explaining how to qualify people with mental disorders as "disabled" (Fieldnotes, 3/2/16). In a 2014 survey, 87% of departmental Disability Offices indicated that psychic handicap was the disability for which they most sought to improve evaluation practices.[33]

Moreover, evaluators clearly evinced that determining whether someone with "psychic handicap" qualified for disability benefits required that they carry out an expert assessment separate from the diagnosis made by psychiatrists in the medical certificate that accompanied applications. As the director of the Disability Office insisted, "You can have very different diagnoses that result in the same consequences…The pathology is an element that is going to clarify things…but it's not the foundation of what we do" (Interview, 7/1/16). His discourse paralleled that of the referent for psychic handicap in the Ministry, who confirmed, "For disability, the diagnosis is not super important, what is important is the consequence. We don't need to know if someone is bipolar or schizophrenic. It was a conscious choice not to make that central to evaluation, because we're in handicap here, not in health" (Interview, 9/7/16).

The evaluation team that assembled to make eligibility determinations, which it based on the information provided to them by the health system and their own interviews with applicants or review of documentation, took seriously the national evaluation guide's admonition to "not position oneself based on the diagnosis."[34] At times, the doctor reviewing the medical certificate would *not* mention diagnoses in discussions of individual cases, focusing only on the observable consequences

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[32] Hardy-Baylé, *Données de preuves.*

[33] Haut Conseil de la santé publique. 2014. *Enquête quantitative sur les modes d'évaluation et de traitement des demandes de compensation du handicap par les MDPH.* Paris, France.

[34] Caisse nationale de solidarité pour l'autonomie. 2013. *Guide des éligibilités pour les décisions prises dans les MDPH.* Paris, France.

of those diagnoses in functioning. They embraced the frequent critique of psychiatric diagnosis as an unreliable classification, dependent on the subjective and inscrutable judgment of the psychiatrist (Craciun 2016; Strand 2011; Whooley 2016). I thus documented a shared understanding—from the central state down to ground-level bureaucrats—of the new classification scheme. Mental illness and disability were distinct categories that could both be present based on the boundary object of psychic handicap.

Simultaneously, these disability evaluators faced pressures to objectify and justify their determinations. One member of the team needed to fill out the 40-page "guide of evaluation of needs for disabled persons" that precisely explained someone's limitations in daily life, independent living, or employment. These determinations could potentially be scrutinized by a departmental commission, composed of representatives of the government and associations for people with disabilities, which heard appeals and reviewed a random sample of dossiers in detail. That commission, in turn, faced oversight from the central state, which was seeking to standardize evaluations and eliminate "deviations in the interpretation of [regulatory] texts," as one ministry document put it. This goal was reaffirmed in 2017 in a new project to ensure "the objectification…[of[the needs of the person…and responses to them."[35] French disability evaluators were thus far from the old "politics of the administrative window" (Alexis 2008; Dubois 2003) in which low-level functionaries could exercise professional judgment largely free from outside surveillance.

In practice, though, psychic handicap was a bureaucratically split personality because the tools supposed to use to produce "objective" evaluations were a poor match for mental disorders. For example, one benefit offered personalized aid for people with "severe" or "absolute" difficulties in one of sixteen different activities. This kind of criteria reflected the vision of disabilities as something that could be precisely measured and documented: a simple set of procedures could show that a who was paraplegic had an "absolute" barrier to feeding themselves or getting out of bed. The Law of 2005 included activities like "orient oneself in time and space," "manage one's security," or "master one's behavior in relationship with others" explicitly in order to cover people with psychic handicaps. But it was very difficult to show that limitations in these domains were "severe" or "absolute."[36] The lead evaluator for this benefit explained, "We are trying to see what is possible or impossible for someone…for psychic handicap, that's complicated" (Interview, 3/9/16). In my coding of reasons for rejection from various benefits, I found that people with mental disorders were far less likely to be found through an expert evaluation to be concretely "insufficiently handicapped" or "too handicapped" to receive benefits (the latter most often referring to help finding employment), but more likely to have an application deferred because of a lack of clear evidence either way (Table 2.2).

Like most tools under the 2005 law, the medical certificate attached to each application was supposed to cover all handicaps, regardless of their origin. It included a series of checkboxes about whether people were autonomous in various daily activities. To Disability Office evaluators' frustration, however, medical certificates describing people with grave, treatment-resistant schizophrenia nonetheless frequently indicated that the person was "autonomous" in activities like "clothe oneself" or "travel outside the home," thus disqualifying them from many benefits (see

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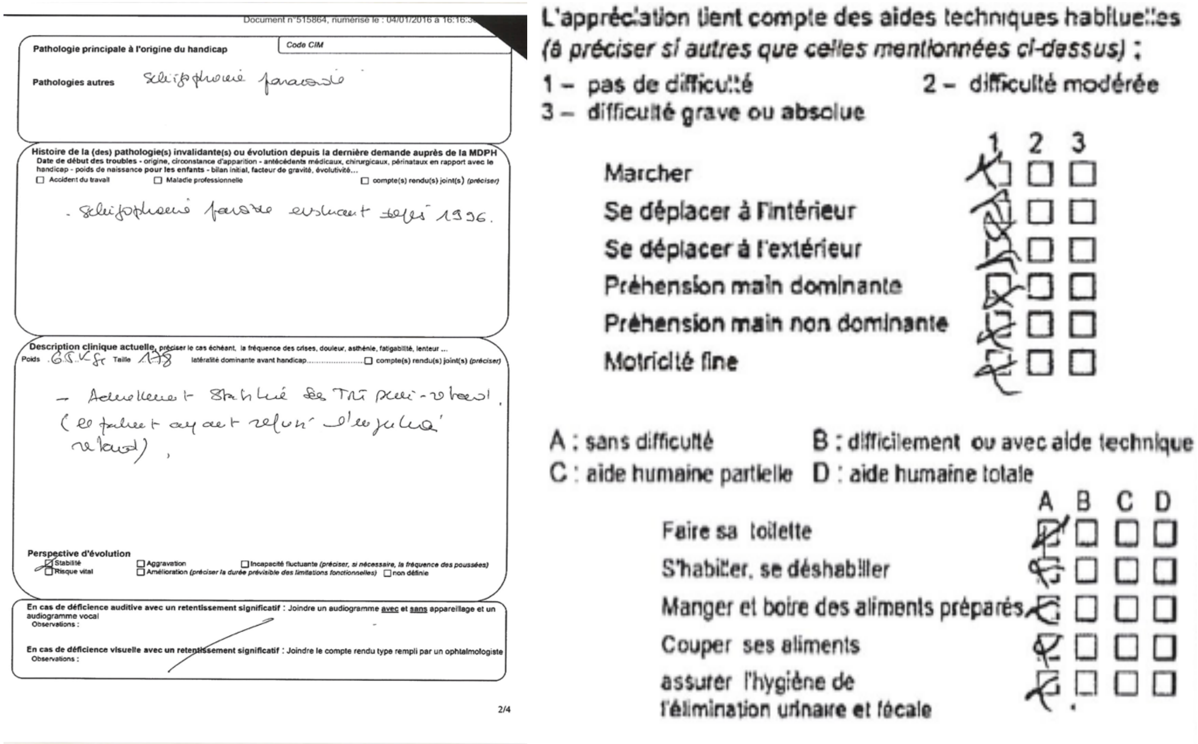
[35] Caisse nationale de solidarité pour l'autonomie. 2017. *Une réforme tarifaire pour faciliter les parcours des personnes handicapées.* Paris, France: 2.

[36] 15.8% of these allowances were given to people with psychic handicaps, even though they constituted closer to 25% of total applicants for disability benefits. Amara, Fadéla, Danièle Jourdain-Menninger, Myriam Mesclon-Ravaud, and Gilles Lecoq. 2011. *La prise en charge du handicap psychique.* Paris, France: Inspection générale des affaires sociales: 30, 70.

Figure 2.5: Medical Certificate for Person with Schizophrenia



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Pathologie principale à l'origine du handicap | Code CIM

Pathologies autres schizophrénie paranoïde

Histoire de la (des) pathologie(s) invalidante(s) ou évolution depuis la dernière demande auprès de la MDPH
Date de début des troubles - origine, circonstance d'apparition - antécédents médicaux, chirurgicaux, périnataux en rapport avec le handicap - poids de naissance pour les enfants - bilan initial, facteur de gravité, évolutivité…
☐ Accident du travail ☐ Maladie professionnelle ☐ compte(s) rendu(s) joint(s) *(préciser)*

- schizophrénie paranoïde évoluant depuis 1996.

Description clinique actuelle, préciser le cas échéant, la fréquence des crises, douleur, asthénie, fatigabilité, lenteur …
Poids 65 Kg Taille 178 latéralité dominante avant handicap…………………… ☐ compte(s) rendu(s) joint(s) *(préciser)*

– Actuellement stabilisé sous TRT neuro-leptique. (le patient ayant refusé l'injection retard).

Perspective d'évolution
☒ Stabilité ☐ Aggravation ☐ Incapacité fluctuante *(préciser, si nécessaire, la fréquence des poussées)*
☐ Risque vital ☐ Amélioration *(préciser la durée prévisible des limitations fonctionnelles)* ☐ non définie

En cas de déficience auditive avec un retentissement significatif : Joindre un audiogramme avec et sans appareillage et un audiogramme vocal
Observations :

En cas de déficience visuelle avec un retentissement significatif : Joindre le compte rendu type rempli par un ophtalmologiste
Observations :

2/4

L'appréciation tient compte des aides techniques habituelles (à préciser si autres que celles mentionnées ci-dessus) ;
1 – pas de difficulté 2 – difficulté modérée
3 – difficulté grave ou absolue

	1	2	3
Marcher	☒	☐	☐
Se déplacer à l'intérieur	☒	☐	☐
Se déplacer à l'extérieur	☒	☐	☐
Préhension main dominante	☒	☐	☐
Préhension main non dominante	☒	☐	☐
Motricité fine	☒	☐	☐

A : sans difficulté B : difficilement ou avec aide technique
C : aide humaine partielle D : aide humaine totale

	A	B	C	D
Faire sa toilette	☒	☐	☐	☐
S'habiller, se déshabiller	☒	☐	☐	☐
Manger et boire des aliments préparés	☒	☐	☐	☐
Couper ses aliments	☒	☐	☐	☐
assurer l'hygiène de l'élimination urinaire et fécale	☒	☐	☐	☐

Figure 2.5). The problem, one representative from UNAFAM pointed out, was that "physically they can get up, get dressed, cook dinner—but they don't" (Interview, 5/9/16). "Disability" has long served as an exemption from certain social expectations—like employment—based on what someone *cannot* do (Stone 1984). A "psychic handicap," defined by limitations to the activities someone *will* do, was incoherent or inapplicable within this framework. The evidence psychiatrists supplied to show psychic handicap failed as a boundary object because it did not "satisfy the information requirements" (Star and Griesemer 1989:393) of each world; they spoke to a troubled subjectivity but not objective incapacities. In one debate over whether to give a Handicap Allocation to someone whose medical certificate described him as having "behavioral problems," one evaluator commented, "Maybe this really isn't a psychic handicap—it's just someone who's frustrated and compulsive!" The example displays how, in these evaluation situations, the "personality" of people who ostensibly had a psychic handicap was "bureaucratically split": the fact that the issue was "psychic" seemed to conflict with the notion that it was a "handicap."

These difficulties in conducting evaluations of psychic handicap that satisfied the bureaucratic requirements of the Disability Office were particularly visible in cases of "anxiety-depression syndrome." Mood disorders have been a central component of the rise of disability rolls in the United States (Berkowitz and DeWitt 2013:223) and now account for 39% of new awards for disability income on the basis of mental disorders.[37] But in Paris (no national data is available), mood disorders were only 21% of an already smaller portion of awards given for mental disorders.[38] My observations suggest that this low rate of awards was not based on a stigmatizing belief that

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[37] Calculation based on Social Security Administration. 2015. *Annual Statistical Report on the Disability Insurance Program.* Washington, DC.
[38] Unpublished statistics (see Note 7).

applicants were malingerers or that giving disability benefits would demotivate a search for employment (Table 2.2).

Rather, rejections stemmed from the way that, in an attempt to comply with the requirement that they document a clear justification for their decisions, evaluators chose indicators that widened the gulf between "people with depression" and "people with disabilities." In particular, in the absence of clear evidence of how anxiety or depression created functional limitations in everyday life, evaluators used two shortcuts—is the person treated by a psychiatrist in a public Psychiatric Clinic? Has the person been hospitalized?—to determine disability. Explained one evaluator:

> We're obligated to grab onto something: is there a treatment, consultations, hospitalizations? Often, the people that show they don't have treatments, that are not hospitalized…by definition are not handicapped. If it's hard to find something in terms of a restriction [of activities], and we don't have lots of elements of treatment, of [medical] following, then it's not serious (Interview, 7/12/16).

In discussing one case, an evaluator was even more explicit: "Tell her that if she wants a Handicap Allocation, she needs to be followed by a psychiatrist in the public sector." The evaluator was *not* directly deferring to an outside evaluation of disability in a form of "burden shifting" or "rubber stamping." Rather, she was using a following by public psychiatry as an indicator of disability in and of itself to be used in her own evaluation.

Inadvertently, disability evaluators reproduced the classificatory logic of French psychiatry which, as I found in my observations of the Psychiatric Clinic, divided between "real mental illnesses" and mere "psychic troubles." Psychic troubles, including depression, were deemed a normal response to difficult life circumstances and not truly medical. For example, in one case, the Disability Office team evaluated a thirty-year-old gradually losing his sight. The psychologist who had interviewed him explained, "He's really in great suffering, grieving for the loss of sight." But when someone noted that his medical certificate mentioned BiPolar disorder, she replied—noting that it was written by a generalist doctor, *not* a public psychiatrist—"No, this is not a psychiatric problem, it's a reaction. Anyone going blind will have this!"[39] Ironically, the agreement as to the reality of this person's sensorial handicap invalidated the claim that they had a psychic handicap as well.

Ultimately, this heuristic *outsourced expertise* because it made evaluations contingent on the prior decisions of public sector psychiatrists over whether to treat someone in a psychiatric clinic, prescribe them medication, or hospitalize them. It thus excluded from disability benefits those who psychiatrists deemed as not having "real mental illnesses" but who technically might meet the formal criteria for disability. Psychic handicap did not serve as a boundary object which bridged separate classifications "without imposing…categories from one community" onto another (Bowker and Star 1999:297). Psychiatric diagnoses—which French psychiatrists did not have to objectify using formal tools or measurements, and which many in the disability system critiqued in the abstract as unreliable and subjective—in effect became disability evaluations.

In a sign of the state and civil society's commitment to the spirit behind the recognition of psychic handicap, various state agencies discussed bureaucratic fixes for these evaluation procedures. Yet many were abandoned as violating the principles of the 2005 reform and the classification system it proposed.[40] On one hand, evaluations could officially rely on psychiatric expertise, thus

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[39] In 42 of 219 cases (19%) where the "primary deficiency" was something other than "psychic", the dossier nonetheless made reference to a "secondary deficiency" of anxiety or depression. This almost never factored into final evaluations.

[40] A key example was "*Potentiel Emploi*" a national experimentation in a detailed evaluation of working capacity centered on people with psychic handicaps. The experiment was not renewed.

defeating advocates' goal of moving beyond a purely-medical understanding of the challenges of people with severe mental disorders. On the other, they could create separate tools and procedures for this population, which would make the challenge of commensurating them with other people with disabilities, discussed in the next section, more severe. In either case, the attempt to use psychic handicap in evaluations showed it to be a bureaucratically split personality. Illnesses that created difficult-to-document troubles of volition and disabilities could not be easily translated into incapacities that the Disability Office could objectively establish.

Institutionalization: Stable Compensation Versus Unstable Troubles

In some cases, the team at the Disability Office could evaluate the medical certificate and life project of a mentally ill applicant, recognize the existence of a psychic handicap, and directly grant a disability benefit like the Handicap Allocation. The full aspiration of advocates, however, was that psychic handicap would enable people with severe mental disorders to enter an existing infrastructure of professional retraining centers, protected workshops, and supported housing for people with disabilities (see Figure 2.2). Institutionalizing psychic handicap, then, required establishing that people with psychic handicaps were commensurate with the disabled people they already served. Here, a tension long embedded in the categories of disability and mental illness—that the latter was fixed and stable, the former unpredictable and variable—constituted another way that psychic handicap was an unworkable bureaucratically split personality.

This contradiction was evident in the "Team for Professional Insertion" at the Disability Office, which determined whether a person who had already been designated "disabled" would be offered help in finding employment (versus given only a Handicap Allocation). As this team knew, France's Centers for Professional Retraining, which were created for people disabled by war or workplace accidents (Romien 2005), sought to compensate for a disability during a long trajectory towards re-employment that included evaluation, pre-orientation, re-training, development of a "project for professional insertion," internships, and only then job searching. The law of 2005 opened these centers to people designated as disabled on the basis of having a psychic handicap. However, their requirement that people be "stabilized"—"a strict precondition" according to one government report[41]—was at odds with the very definition of psychic handicap given by UNAFAM and other advocates, which emphasized its "variability" and "the need for constant adjustments."[42] As one psychologists who worked on professional insertion observed at a training, "We should remember that we're dealing with a population [mentally disordered] that at any moment could fall apart and we have to start again from zero."

The delay with which the Disability Office treated applications was undoubtedly frustrating for all applicants but particularly problematic for those with mental disorders. One day, the team debated a 53-year-old woman whose two-year-old medical certificate described a "chronic psychosis" and "heavy treatment." The team's doctor commented, "If she hasn't been in the hospital since then, maybe she's okay…" But the psychologist from the retraining center replied, "No. She could be totally delirious. We've done this before and it hasn't worked out. Can we just say she's 'still in care' and give her a Handicap Allocation?" While evoked in only 5% of other rejected demands, the team used "still in treatment" as a justification 40% of the time in refusing a request from someone whose limitations stemmed primarily from a mental disorder (Table 2.2). Confronted with this observation, one psychiatrist working in a service for professional insertion admitted that

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[41] Le Houérou, Annie. 2014. *Dynamiser l'emploi des personnes handicapées en milieu ordinaire.* Paris, France: Assemblée Nationale: 24.
[42] UNAFAM, *Le livre blanc,* 12.

"the notion of 'handicap' in psychiatry is not that interesting if you say that it's something stable and fixed. 'Stable' means nothing, in terms of psychiatric pathologies…just call it a chronic illness" (Interview, 3/26/16).

This same contradiction appeared in France's extensive system of "protected workshops" (see Figure 2.1). These are organized around the model of a disabled person (classically, someone with intellectual disabilities) who could produce predictably and reliably at some level lower than that of a "normal" worker, with the difference made up for by state subsidies. These facilities had an interest in taking people with psychic handicap because prenatal screening and abortion meant the population of people with conditions like Down's Syndrome was decreasing. Yet when the directors of these institutions actually brought people designated as having a psychic handicap into their establishments, they struggled to commensurate them with their institutionalized schema of "disability":

> These are people [with a psychic handicap] who are one day capable of taking lots of initiative, lots of responsibilities, very technical things, and another day, they can't tie their shoes…That's the difficulty, not because they don't know how, not because they can't do it, but because some days, they just don't do it! (Interview, 3/4/16).

My interviews suggested these difficulties were more about practicality than stigma towards the mentally disordered. Because protected workshops largely cannot fire workers once they have been hired, managers had to continue to pay mentally disordered persons even when they were on long sick leave due not to their *handicap,* but their *illness*. As such, despite the "preservation of intellect"[43] that UNAFAM claimed marked people with psychic handicaps and the frequently referenced archetype of the "schizophrenic with three masters' degrees," many managers thus declared that people with intellectual disabilities were preferable. The latter were better able to meet the key metric by which they measured the disabled: their "capacity to maintain their work over time" (Interview, 2/24/16), or, to put it another way, their "stability." The result was that only 6% of places in protected workshops in the Parisian region were dedicated to individuals with primarily mental disorders.[44]

In France, being "psychically handicapped" presents a disordered, contradictory split personality with respect to work. On one hand, France has long been seen as a leader in promoting the employment of "disabled" persons (Power et al. 2014) and its formal policies for encouraging employment among people with mental disorders are recognized as among the strongest in Europe.[45] I observed that at least some of the gatekeepers of employment for persons with disabilities—the Disability Office, "ordinary" firms, and protected workshops—made genuine attempts to fit people with mental disorders into existing institutions. But, once admitted, they determined that they were a poor fit, and thus began turning around new candidates. By default, then, they made the primary bureaucratic identity of this population "mentally ill." And, in contrast to its employment-focused disability policy, France's generous paid sick leave means that it has among the highest proportions of the population among rich countries who are *not* working because of *illness*.[46] As the director of the Disability Office observed, "There is a social cleavage between 'I'm sick' and 'I'm going to work' in France" (Interview, 7/1/16). Thus, when government statistics show that very few people labeled as having a "psychic handicap" are employed, the reason is that,

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[43] UNAFAM, *Le livre blanc,* 12.

[44] Agence régionale de santé. 2011. *Projet Régional de Santé : Schéma d'organisation médico-social.* Île-de-France: 45.

[45] Economist Intelligence Unit. 2015. *France Country Report.* Retrieved December 21, 2016 (mentalhealthintegration.com).

[46] OECD Health Statistics. 2012. Retrieved September 13, 2017 (http://www.oecd.org/els/health-systems/health-data.htm).

as one workshop director explained: "I've realized that these people aren't really handicapped! They're just sick!" (Interview, 4/19/16).

Difficulties of commensuration, rather than overt classification struggles, created problems for long-term disability housing as well. Across the health and disability systems, nearly everyone I interviewed endorsed the goal of reducing the number of chronically ill patients languishing in hospitals. Here, again, contradictory behavioral expectations were a problem. These facilities were charged with promoting the active social participation and rehabilitation of their tenants. But, as the person responsible for handling housing placements at the Disability Office explained:

> When you're at the hospital, everything is organized for you. They tell you when to get up, when you sleep, and the rest of the time, you do nothing. In supported housing, you have a collective life, activities all day. If you're not used to it, it's exhausting. And this constant solicitation to do things that you're not in capacity to do, it creates frustration and behavioral problems… and you go back to the hospital (Interview, 2/25/16).

A social worker from the Psychiatric Clinic recounted the case of a patient who had been involuntarily hospitalized for three years, and who would collect cigarette butts and eat them. Working with the Disability Office, they found a place for him in a nursing home but they "sent him back to us because they said that he wasn't willing to participate in group activities, he just wanted to eat cigarette butts. And I was like, 'yeah, that's the point'" (Interview, 3/4/16). This back-flow was significant, equivalent to about 22% of the people leaving psychiatric hospitals for disability housing.[47]

These challenges were not a matter of simple gatekeeping by housing establishments; the directors of the private associations that run them who I talked to actually wanted to tap into a growing population with psychic handicap. But, in a manner consistent with the idea of psychic handicap as a boundary object, they usually demanded that the public psychiatric teams sign a convention agreeing to re-hospitalize those individuals when necessary. The problem was that, when they did hospitalize patients whose symptoms flared, the homes were required to hold that person's bed, but were only paid one-third their usual rate by the state. The solution, the head of placements in disability establishments at the Disability Office explained, was that "now the establishments want a guarantee that the person is 'stabilized'…which means they [people with psychic handicap] are never going to make it" (Interview, 2/25/16). This refractory looping reaffirmed a meaning of disability that increasingly excluded psychic handicaps. In 2014 statistics for the Parisian region, 45% of the people who had been approved for residential services by the Disability Office but not found a structure willing to take them had a psychic handicap.[48]

At the time of research, efforts were being made to facilitate the entrance of these populations into supported housing. Doing so, however, required a profound break with a model that provided the same daily payment for all categories of disabled persons. It thus entailed the slow process of building new specialized institutions *only* for the "psychically handicapped"—which, increasingly, were simply converted pavilions of psychiatric hospitals. There, one ministry official admitted, "the color of the blouses has changed, but the practices are the same" (Interview, 2/28/16). As was the case when the Disability Office outsourced expertise, "psychic handicap" was being treated more as a synonym of "severe mental illness" than a true boundary object. Innovative programs—like worksite "Job Coaching" or rapid-entry "Housing First"— relied on funding and expertise from the health system and abandoned the expectation of "stability" around which the disability system was organized.

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[47] DREES, *Les établissements et services pour adultes handicapés,* 269-273.

[48] MDPH 75. 2014. *Rapport d'activité.* Paris, France: 61.

Once again, these findings speak to the role of the particular configuration of the French welfare state in shaping what happened when the contradictions of a bureaucratically split personality emerged. Unlike the targeted disability system, in which people needed an affirmative evaluation from the Disability Office and to be accepted by an institution, France's universal health system had no prerogative to refuse people (Bauduret and Jaeger 2005), making them, through *classification by default,* the institutions of first and last resort. One day, the social workers looked over a case of a hospitalized patient that had been referred to them for application to the disaability system. One social worker read off features of the patient while another stated "ha-ha" sarcastically after each, a sign of the hopelessness of any such application: "hospitalization after stabbing," "no immigration paperwork," "chronic addiction," "attacked a nurse," "recent imprisonment." The social worker threw up her hands, "I do what with him? He's not stable. There's no possible 'project.'" A psychiatrist in the same *secteur* explained that "the really difficult patients, the ones who killed someone or tried to, they're going to stay in the apartments of the *secteur*," not disability establishments (Interview, 5/13/16).

Outside the hospital, the lower level Psychiatric Clinic staff remained the de-facto sources of advice in looking for employment, facilitators of social activity, and aids for daily life ("we're nurses specialized in assembling IKEA furniture," one joked). They encouraged people with severe mental disorders to eke out a living using public housing or the minimum income available all poor people. These programs required neither stability, nor self-identification, nor a clear documentation of functional limitations and thus were the fallback source of solidarity for those deemed incommensurable with the disabled.

Conclusion

Why did the introduction of "psychic handicap" fail to effect the intended transformation of people with severe mental disorders from passive objects of medicine to individuals capable of managing an autonomous life project, aided simultaneously by both the medical and disability systems? For some advocates, the law of 2005 had not carried sufficient funding or political will for implementing the gamut of services official recognition of "psychic handicap" had promised. They blamed a lack of financial commitment from the state, resistance from psychiatrists, and an unwillingness of institutions in the disability system to welcome this population into their services. These explanations correspond to theoretical ones in the literature on classification struggles (see, e.g., Abbott 1988; Goldberg 2005; Steensland 2006) and are undoubtedly partly true.

I also, however, presented counter-evidence to these explanations. Policymakers and administrators endorsed the change and psychiatric professionals acquiesced to it. My ethnographic observations show how, at the micro-level, social workers in the Psychiatric Clinic and evaluators in the Disability Office labored collectively to try to adapt the tools, procedures, and regulations given to them to a new population (see Kellogg 2011). The recognition of psychic handicap as a basis of disability, on top of an existing bureaucratic identity of mentally ill, entailed clear material benefits that ought to have driven requests for classification (Liu et al. 2010). This counter-factual of a transformative new classification is even more plausible given the success of French parents in the 1990s in establishing autism (which was ultimately called "cognitive handicap") as the basis for a bureaucratic recognition of their children as disabled (Chamak 2010).

My analysis starts with the recognition that, in analyzing a state classification like psychic handicap, "although it is possible to pull out a single classification…in reality none of them stands alone" (Bowker and Star 1999:38). In this case, the introduction of psychic handicap was supposed to serve as a boundary object that would facilitate the simultaneous classification of people with severe mental disorders as mentally ill and disabled. But the classifications of mental illness and disability continued to bare the imprint of the different arms of the state in which they originated.

Each arm had contradictory behavioral expectations, principles of expert evaluation, and typologies of persons they served which, in the new classification scheme, came to apply to the same people. This prompted processes of *outsourcing expertise, classification by default,* and *refractory looping.* Although these mechanisms harken to classic themes in the literature on street-level bureaucrats like "rubber-stamping," "gatekeeping," or "burden shifting" (Lipsky 2010; Prottas 1979; Seim 2017), they specify how a bureaucratic split personality led to the specific outcome based on the particular structure of the French welfare state. As in the case of the clinical treatment of "split" or "multiple personality disorder" (now referred to as "dissociative identity disorder"), the ultimate solution was the "reintegration" of these contradictory bureaucratic personalities into a single, unified human kind: mentally ill.

These findings are surprising in light of research on "boundary objects" that claims that very different professions can maintain radically different practices and visions of the objects of their work so long as they are linked by some common categories or tools (Bowker and Star 1999; Mol 2002; Star and Griesemer 1989). Why was the mighty French state unable to simply reconfigure the boundary object of psychic handicap to satisfy the needs of both the health and disability system? My results speak to the issue of scale: psychic handicap really was a logically consistent boundary object at the national scale of policy and even, to an extent, for the heads of the Psychiatric Clinic or Disability Office. But for the nurses and social workers who bore the brunt of preparing applications or the psychologists and special educators responsible for filling in the tables and checklists of the Disability Office, that psychic handicap was a bureaucratically split personality was evident. Even once these problems filtered upwards, they were difficult to resolve because what was at stake was not just an administrative label but a "personality." Interventions by the health and disability systems were organized by distinctive visions of the kinds of people they served. Trying to change those kinds—by, for example, suggesting that the preferences of people with disabilities could be over-ridden if, like people with psychic handicap, they lacked "insight" into their need and limitations (Gong 2017)—would most likely have undermined the consensus on which the 2005 reform rested and sparked a true classification struggle.

This negative case can point to reasons why the classification of "disability" has been much easier to apply to the mentally disordered in other contexts. In the U.S., the dominant system of psychiatric diagnoses—the Diagnostic and Statistics Manual—incorporates an evaluation of functional limitations (Whooley 2016). Disability evaluations are initially more purely medical (Powell 2010; Stone 1984) and diagnosis is thus deliberately "objectified" as disability. People with psychiatric disabilities are commensurate with other people with disabilities insofar as the category of "mental disability" was already in use by government agencies by the 1970s; mentally disabled persons formed an early part of the model around which the disability system is based (Bagnall and Eyal 2016). Moreover, as the U.S. has cut back even residual welfare programs, the mentally disordered have no option other than asking for the designation of disability, which gives access to a minimum income and Medicaid insurance (Hansen et al. 2014). Ironically, while the rising numbers of people receiving disability benefits on the basis of mental illness has provoked continuous political consternation in the U.S. (Berkowitz and DeWitt 2013), the classifications "mentally ill" and "disabled" have proven logically compatible, even without a bridge like "psychic handicap." As this example suggests, we need greater attention to cross-national differences not just in the prevalence of classifications like "disability" but the meaning and nature of state categories that make them easier or more difficult to apply (see Carson 2007; Fourcade 2009).

In calling attention to the features of classifications themselves, "bureaucratically split personalities" point to other key axes for analysis. Classifications may require validation from a single bureaucrat or demand information and collaboration of a network of experts. Institutions can vary in the extent to which they broadly or narrowly construct the population they serve, and thus the degree of commensuration they expect between them. Crucially, categories can be to a greater or lesser degree ascribed: states can unilaterally incarcerate those they label criminals and intern those they label mentally ill, but new welfare programs that seek to "empower" or "make autonomous" the poor require a greater degree of engagement, even if that engagement loops back to modify the meaning of the category. Finally, re-classification may take the form of a wholesale replacement of one classification into another, like relabeling people with autism disabled and not mentally ill (Chamak 2010; Eyal 2013). Alternatively, they may consist of layering classifications on top of one another, as was the case with psychic handicap. The latter may be more likely to create bureaucratically split personalities; the former overt classification struggles.

More broadly, this perspective has important implications for a growing literature on how states establish key lines of division and social identities in their subject populations (Bourdieu 2015; Loveman 2014; Starr 1992). Psychic handicap appears as a case of the seeming buildup of classifications over time through projects that apply previously mutually-exclusive categories to the same people. Research points, for example, to the simultaneous management of the "poor" through both a medicalization *and* a criminalization of their identities in the eyes of the state, processes once thought to be opposing principles for intervention (Bosk 2013; Lara-Millán 2014; Seim 2017). These analyses run parallel to work in the sociology of mental health that appears to identify an endless expanding reach of psychiatric classification (Conrad 2007; Horwitz 2001; Rose 2006a). Yet even if the state and medicine appear to construct an ever-more-elaborate "iron cage" of classification (Bowker and Star 1999:320; see, also, Foucault 1991), this research helps identify the circumstances that limit attempts to layer and recombine classifications. Work that develops the now frequent recognition that the state's "many hands" can act in ways that are "incoherent" (Morgan and Orloff 2017:3, 18), "contradictory" (Goldberg 2005:342), or "ambiguous" (Mora 2014:188) should consider how bureaucrats not just struggle over categories with one another, but struggle with the categories themselves.

What this case reveals is that it is precisely the state's strength—its ability to marshal the "material and symbolic resources to impose the…classificatory schemes…with which bureaucrats, judges, teachers, and doctors must work" (Brubaker and Cooper 2000:16; see, also, Loyal and Quilley 2017)—that made psychic handicap a contradictory bureaucratically split personality. There are no inherent characteristics to "disability" and "mental illness" that make them incompatible: rather, it was precisely the long process of forging these two populations as true, distinct human kinds in state institutions that made merging one into the other so difficult. Orderly systems of population classification, then, must emerge from resolving the disordered systems that states themselves can create.

Chapter 3: The Mental Illness Merry-Go-Round: Reconstructing California's Continuum of Constraint

"The pressing problem with regard to the future of the insane in this country is: how can the chronic insane pauper be more cheaply cared for, consistently with a proper regard to humanity" – Frederick Wines, Secretary of the Illinois Board of State Commissioners of Public Charities (1879)

In 2019, across California, policymakers are breaking taboos around how to talk about mental illness—and not with the empowerment discourse of "recovery" from an "illness like any other" that advocates for de-stigmatizing mental illness usually envision. At an April hearing in San Francisco, a representative of the Department of Public Health told a County Supervisor they needed to "provide more services on the voluntary, community side." The supervisor responded, unconvinced: "Sometimes people need involuntary treatment. We fought about locked placements, but now we see we need them…We shouldn't shy away from that." Another supervisor elaborated, "We see every day the results of the broken mental health system…Ronald Reagan shut down the state hospitals 40 years ago, and that's still all we are talking about." Ritual denunciations of the miserly Republican have allowed policymakers to maintain a 50-year discourse that, as a 1980 Federal Report declared, "most mentally ill people, including those perceived as being severely ill and disabled, can live in their home communities" if only provided the right (and well-funded) "support…treatment, and services."[1] In California, this apparent consensus is cracking. Observing how people with mental illnesses and substance use disorders seemed to reject the services offered to them as they bounced between short-term hospitalizations, shelters, and jails, the first Supervisor declared, "We have psychotic people who are using [meth], they're on a merry-go-round, a hamster wheel, and it's time to get them off" (Fieldnotes, 5/1/19).

Another taboo was broken a few weeks earlier in the state capitol, when mental health providers, hospital CEOs, family advocates, and the Mayor of Sacramento gathered for a forum on the "Shrinking Safety Net of Licensed Residential Facilities" for people with severe mental illness (Fieldnotes, 4/11/19). Amidst the dazzling injustice of former asylum patients trans-institutionalized to prisons and jails or dumped on the street, this network of private Board and Care or nursing homes—which Scull (2006:93) calls a system of "privatized malign neglect" that recreated the abandoned back-wards of the state hospital in the margins of the "community"—has largely gone unremarked. But in the face of economic pressures and competition to flip beds previously dedicated to the mentally ill to more lucrative populations like the elderly or developmentally disabled, though, this "precious housing resource" was disappearing at an "alarming rate."[2] In a shocking admission for a prominent figure in a mental health system that has made "independence" and "recovery" its mantra for decades,[3] the head of the Los Angeles Department of Mental Health declared, "for some people, Board and Care is permanent housing…and it's evaporating before our eyes" (Fieldnotes, 4/11/19).

Policymakers, providers, and advocates are talking about themes that have been long submerged in discussions of the mental health system in the U.S.: chronicity, long-term care, and

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[1] Steering Committee on the Chronically Mentally Ill. *Toward a National Plan for the Chronically Mentally Ill.*.

[2] Kelly, Caroline, Barbara B. Wilson, Kerry Morrison, and Brittney Weissman. 2018. *A Call to Action: The Precarious State of the Board and Care System Serving Residents Living with Mental Illness in Los Angeles County*. Los Angeles, CA: Los Angeles County Mental Health Commission - Ad-hoc Committee on LA County's Board and Care System: 5,7.

[3] The congruence of "recovery" with a neo-liberal push to render the mentally ill "autonomous" from long-term dependence on public services is documented by Padwa et al. (2016) and Myers (2010).

involuntary treatment. This chapter follows suit. I analyze tightly (if not always explicitly) linked initiatives to expand lasting involuntary guardianships—called "conservatorship"—and preserve long-term care facilities in California. I draw on policy documents and eighty-one interviews with county conservators, public defenders, and providers throughout the state. I also use observations of working groups and hearings at the state level and in San Francisco, as well as my ethnography of an outpatient clinic in the Bay Area (discussed in Chapter 1), to make three claims.

First, conservatorship reveals the paradoxical mix of public and private authority in the American mental health system's exercise of legal constraint. While because of federal law[4] hospitals cannot completely refuse short-term civil commitments of the kind discussed in Chapter 4, conservatees are usually placed in for-profit institutions (like Board and Care homes) that have discretion over whether to accept them. The efficacy of conservatorships further relies on these institutions to provide the minimal services necessary to control those individuals. But, as I show, precisely the populations that policymakers and the general population would like to see coerced and conserved are filtered out by the way that public actors accommodate private institutions' preferences for certain kinds of mentally ill clients. With respect to another private actor—the family—the system less delegates responsibility so much as it completely offloads it. This paper thus explores some of the contradictions in America's fragmented welfare state based on a case study of the management of individuals torn between the states caring "left hand" and its coercive "right hand" (Bourdieu 1999).

Second, the declining use of conservatorship and shriveling Board and Care industry (at least for the severely mentally ill) has robbed the public mental health system of a key tool for stabilizing the severely and chronically mentally ill ("stability" here referring not to lessened symptoms, but an end point of a trajectory between institutions). Treatment and housing providers in California are increasingly confronted with a difficult to disentangle mix of homelessness, perceived criminality, methamphetamine addiction, and mental illness attributed to the same individuals. As I show through a case study of San Francisco, the agencies potentially responsible for these populations shunt responsibility onto others by asserting that people are, above all, really criminals, drug addicts, or mentally ill. The result is a chain of interventions akin to what the Supervisor cited above called a "merry go round," a kind of "institutional island hopping" between service providers, short-term housing, and judicial agencies. The movement is more stochastic and random than "trans-institutionalization" and less orderly than the notion of an "institutional circuit" (Hopper et al. 1997) or the French idea of psychic handicap as creating a smooth "*parcours*" [trajectory] between disability and medical institutions imply (Féry-Lemonnier 2014).

Finally, in the conclusion, this chapter points to two possible futures for public mental health care for the severely mentally ill in California and, potentially, the U.S. as a whole. One is a new "continuum of constraint," by which novel mechanisms of legal coercion in the community are carefully calibrated to manage the disorder caused by the severely mentally ill at minimum cost. As I show throughout, even for the most chronically mentally ill, discourses around patient "choice," a seamless recovery-oriented "continuum of care," and "stepping down" to less intrusive and intensive services mean that long-term solutions usually have to be couched in assurances that the mentally ill will remain in constant motion between levels of care. Such a continuum would be an involuntary parallel to the rational ratcheting up and down of voluntary services described in Chapter 1. The other possible future, raised in the opening anecdotes, is an abandonment of these

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[4] In particular, the Emergency Medical Treatment and Active Labor Act (1986) requires hospitals receiving federal funds (nearly all of them) to screen people presented to them for an emergency medical condition, to treat and stabilize that condition, and to accept transfers from other hospitals that lack capacity to treat a special medical condition.

shibboleths in favor of a genuine, if necessarily partial, re-institutionalization, in which chronicity is met with a combination of long-term custodial care and of constraint. I speculate on the evidence for such a swinging back of the institutionalization pendulum in the conclusion.

Literature Review

Conservatorship: Commitment for the Disabled but Not Dangerous

Three of the most iconic scholars of psychiatry and social control—Robert Castel (1988:3), Michel Foucault (1964:205), and Erving Goffman (1959:130)—all spoke of psychiatric internment as establishing "guardianship" over the mentally ill. The term evoked how they envisioned the relationship between the psychiatrist and patient. Civil commitment into asylums was an exercise of the state's *parens patriae,* or its obligation to care for its most vulnerable citizens. The psychiatrist assumed the role of the paternalistic protector, irrespective of that person's protestations in favor of their own liberty and autonomy.

Few would describe the relationship between inpatient psychiatrists and patients today in terms of "guardianship." For one thing, litigation through the 1960s and '70s progressively pushed the justification for civil commitment from the state's *parens patraie* to its police powers, or authority to prevent danger and disorder (see Chapter 4). The most important manifestation of this change has been the adoption of a dangerousness standard for involuntary psychiatric commitment in every state except Georgia (Hedman et al. 2016), a move mirrored in most Western countries (Dressing and Salize 2004; Dressing, Salize, and Gordon 2007).[5] Sociologists, legal scholars, and psychiatrists have subsequently spilled a great deal of ink arguing over whether medical professionals actually have any particular expertise in making this crucial determination of "danger to self or others."[6]

These perspectives presume that most involuntary psychiatric admissions are for short-term stabilization, and incapacitation. Irrespective of the validity of evaluations of danger, the severely mentally disordered are likely to leave hospitals rapidly anyway. These studies have by-and-large overlooked two important points. First, in most states, either the legislature or the courts have created an alternative to the dangerousness standard: admissions based on "grave disability" or "inability to meet basic needs." Psychiatrists have noted (approvingly) that "grave disability" may function as a work-around to the strict criterion of danger to self or others (Appelbaum 1994; Monahan 1977).[7] As one professional told Holstein (1993:56) "If we're arguing disability, almost anything goes." Although, as discussed below, "grave disability" may rarely constitute a successful argument for getting a severely mentally ill person into a hospital bed in the first place, numerous—if dated—studies have claimed that this criteria accounts for between 75 and 90% of long-term placements in locked institutions, which usually must be approved by judges (Holstein 1993:55; Parry, Turkheimer, and Hundley 1992:33; Warren 1982:40).[8]

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[5] On the other hand, some countries in Asia and some less developed countries maintain a standard based on need for treatment, professional judgment, and the preferences of family members (Chen et al. 2017; Fischer 2005; Loue 2002). As noted in Chapter 4, a "need for treatment" standard persists alongside a "dangerous/public order" standard in France, as well as in Italy and Israel (Aviram 1990; Gourevitch et al. 2013; Steinert and Lepping 2009).

[6] Classic critical perspectives, which describe psychiatric evaluations as no better than a coin flip, come from Ennis and Litwack (1974) and Morse (1982). Dallaire et al. (2000) and Pfohl (1979) provide a sociological take. Medical researchers have countered that clinicians can make consistent and valid dangerousness determinations (Segal et al. 1988).

[7] Indeed, in their review of Supreme Court jurisprudence, Simon and Rosenbaum (2015:8) conclude "the Court's broad conception of 'danger to self' seems to allow substantial room for the development of grave disability standards that contemplate intervention before acute crisis." As I show, intervention *after* acute crises, based on "grave disability," are probably more common.

[8] In Chapter 4, I report on civil commitment hearings in New York; lawyers for the hospital assert the patient's inability to care for their basic needs in one-third of retention and release hearings.

The existence of a "grave disability" standard suggests a second point overlooked in the literature: the United States still really does have "guardianship" in the traditional, paternalistic sense, at least for some of the chronically mentally ill. As is the case for people with developmental disabilities or the dependent aged, states allow courts to appoint a third party to manage the fiscal and personal affairs of incapacitated adults with mental illnesses. While some have portrayed these as a less-restrictive alternative to civil commitment (Lamb and Weinberger 1993; Loue 2002), the powers granted to guardians are extensive. In California, "conservators" for the mentally ill—usually, employees of a specialized county office that handles guardianships—have the right to consent to (or impose) medical and psychiatric treatment, determine where a conservatee will live, and control how any income they have is spent.

In contrast to civil commitments, research on conservatorship (or mental health guardianships more generally) is minimal (cf. Eyraud 2013).[9] The few studies on the conserved population in California (carried out in the 1980s) identify people under conservatorship as extremely vulnerable and ill, with extensive histories of psychiatric hospitalizations, substance abuse, psychotic symptoms, violence, and homelessness (Frank and Degan 1997; Lamb and Weinberger 1992, 1993; Reynolds and Wilber 1997; Young, Mills, and Sack 1987). Conservatorships seemed to help increase stability among patients who did not have families (Lamb and Weinberger 1992) and, unsurprisingly, increased the degree to which their basic needs for food, clothing, or shelter are met (Frank and Degan 1997).

The only other empirical studies on conservatorship have analyzed the efficacy of legal safeguards for people under or potentially under conservatorship. In California, attorneys for the mentally ill in conservatorship cases in 1975 only asked questions of the psychiatrists testifying one-third of the time (Morris 1978). In 2009, they usually waived their client's right to a hearing. In only one of 298 cases was a conservatorship not granted on the basis of a contested hearing (Morris 2009). These data speak to the continuing hold of a vision of the mentally ill as disabled and needing paternalist protection, alongside more frequently articulated discourses around the opposite poles of recovery and dangerousness.

Conservatorship is, in effect, a way for the state to scream "stop" for patients on a merry-go-round of hospitalizations, incarcerations, and homelessness. However, there is virtually no contemporary research on how public conservators and clinicians use "grave disability" to extend psychiatric constraint or where conservatees actually end up. In particular, no studies analyze the intersection between conservatorship and the shifting network of long-term care outside of hospitals into which conservatees are supposed to be placed, as discussed in the next section.

Trans-Institutionalization: From Public Wards to Private Profits

Most scholars now understand de-institutionalization as "trans-institutionalization" by which the locus of control (more so than care) of the mentally ill shifted to less medicalized spaces. The most obvious form of this trans-institutionalization is the increasing number of mentally ill in prisons and jails (Roth 2018), although the actual extent to which state hospital residents moved directly into prisons is debated (Lamb and Weinberger 2005; Raphael and Stoll 2013; Yoon et al. 2013). Less remarked, but quantitatively more indisputable,[10] was the shift of severely mentally ill

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[9] In fact, being conserved has (for reasons of difficulty of obtaining informed consent) actually been a cause for *exclusion* from some studies on California's response to severe mental illness (Starks et al. 2017)..

[10] One piece of evidence for this shift is that people over 65 showed the largest and most rapid decline in state-hospital residency (70.6% from 1955 to 1973, dropping from 41% to 22.7% of state hospital residents) (Frank and Glied 2006:95–96).

directly from state hospitals into Board and Care homes, single-room occupancy hotels, or nursing facilities, which by 1989 had together become "the largest locus of mental health 'care' and expenditure" (Brown and Cooksey 1989:1130). Good numbers are extremely hard to come by, in part because many residents of these facilities have 'co-morbid' dementia, potentially less-severe mental illnesses like depression, and developmental disabilities. Davis et al. (2012) estimate that there are now twice as many severely mentally ill in these facilities as in hospitals.[11]

From one perspective, these narratives of trans-institutionalization suggest that not much has changed: the everyday lives of marginalization and neglect of the chronically mentally ill have been "little affected" (Estroff 1981:253–54) by de-hospitalization. "There is," as such, "no sign that the isolation of mental patients is a thing of the past" (Castel et al. 1982:122). But simply talking about "trans-institutionalization" of the severely mentally ill overlooks an important shift in the political economy of *how* states pay for care for the mentally ill. As noted in the Introduction, Federal and State governments continue to cover a larger share of expenses on the severely mentally ill than for other health conditions. However, while in the past that money came directly from state general funds, it now largely passes through Medicaid and Social Security Disability payments (Figure 0.12).

The ultimate recipients of those payments are, by and large, private actors. Indeed, thanks to Medicaid and Social Security, an American health system that previously bifurcated between a largely-private acute care sector and a largely-public system of institutions for the mentally ill, disabled, and aged (Starr 1982:173) now has an enormous private sector dedicated to custodial care (see Levitsky 2008). As Scull observes, while public asylums in England grew in the 19th century partly out of exposés of horrendous abuses in private boarding houses, with those asylums' disappearance "welfare payments have once more transformed mental patients into a lucrative commodity" (Scull 1981:747). As I show, "lucrative" is perhaps an overstatement, but re-conceptualizing conservatees as both sources of potential private revenues and as public burdens is crucial to understand the contemporary trajectories of the severely mentally ill in California.

These are a specific kind of commodity, though. For one thing, as human beings, they can (and do) resist their placement in these facilities. As a result, their transformation into a privatized commodity depends on the public power of the courts. The Social Security Administration, for example, can establish a "payee" who receives a disability check on someone's behalf (and thus can choose where to spend all but a residual of it) (Monahan 2011). More drastically, as this paper describes, courts can use conservatorship to legally obligate a person to live in a private facility. What they *cannot,* by and large, do is mandate a specific facility to take a given person. Nor can courts render all mentally ill commensurate with one another; some of these commodities are more violent, more addicted, and more uncooperative, and thus less profitable. Indeed, research on private psychiatric hospitals has clearly shown their hesitancy to take the most difficult patients, which has driven those patients to a set of public institutions that will take them—jails and prisons (Yoon 2011). This interplay between public legal power and private profit-making is part of what makes California's mental-illness merry-go-round so dizzying for those left spinning on it.

Homelessness and Institutional Island Hopping

A final body of literature has focused specifically on the role of the mental health system in the lives of the homeless population. While some scholars quickly connected de-institutionalization

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[11] Davis et al. put the figure at just over 400,000, but other estimates are much higher. Grabowski (2009) estimates a half-million for nursing homes alone. Because of the IMD exclusion, which cuts off Medicaid when more than half of residents have a primary diagnosis of mental illness, homes have strong incentives to make these diagnoses secondary.

to the expansion of homeless populations in the 1980s (Dear and Wolch 2014), others have been more consistently critical of the "medicalization" of homelessness. First, blaming homelessness on mental illness at the level of policy discourse displaces responsibility from the system onto the individual and distracts from more structural responses to poverty (Lovell 1992; Snow et al. 1986). Second, a "pop medicalization" has sought to make homeless individuals discipline themselves through correcting their own perceived failings, from poor anger management to a lack of budgeting skills, guided by a minimal amount of non-professional therapeutic guidance, often from "recovered" peers (Gowan 2010; Lyon-Callo 2000; Ricciardelli and Huey 2016). Third, city governments have used medicalization in a more heavy-handed way, justifying police sweeps and mass forced hospitalizations with professed concern for mental illness (Mathieu 1993; Stuart 2014).

A second strand in this literature has flipped the question: what role do institutions of homelessness play in the lives of the severely mentally ill? Hopper et al. (1997:660) describe the "shelters and custodial facilities linked in haphazard chains of time-limited occupancy" that make up an important part of the "institutional circuit" alongside hospitals and jails. Gowan (2010:187), similarly, analyzes a "homeless archipelago" of shelters, rehab centers, and (limited) transitional housing that is supposed to serve as a "continuum of care" towards reintegration into normal, productive life. In practice, individuals generally move "in a more circular than linear fashion" (Gowan 2010:208). The image is something like that of Malinowski's Argonauts, endlessly paddling between islands of service provision that allow them to exchange their "disabilities, diagnoses, and deficits" (Estroff 1981:119) for the bare-bones necessities of survival. These approaches have emphasized the scrappiness of the de-institutionalized mentally ill in drawing resources strategically from a multiplicity of government agencies (Lewis et al. 1991).

This paper examines a period where this institutional circuit is being disrupted. In 1977, Andrew Scull observed the rapid decrease in state hospital populations and concluded that "a policy of de-carceration has clearly been pursued most rapidly and universally in the handling of the mentally ill." He speculated, though, that it would not end there: "state-sponsored efforts to de-institutionalize deviant populations" would soon encompass "such deviant groups as criminals juvenile delinquents, and the mentally ill" (Scull 1977:77, 3) in tandem. It was, given the spike in incarceration that began in the 1980s, an interesting but not very prescient argument, which he himself corrected (Scull 2015:378). But this broad-based de-carceration, arguably, is finally really happening in present day California. Both policies of "realignment" to reduce prison population and the closure of Board and Care homes have thrown more chronically mentally ill into the vast sea of homeless people competing for a finite number of shelter, Single Room Occupancy hotel, and supported housing beds.

Rather than an institutional "circuit," I describe how at least some number of the homeless mentally ill are locked into something more akin to "island hopping": jumping from one type of service to another, none of which accepts responsibility for them or allows them to stay for very long. These institutions are not linked into any coherent circuit which individuals can learn to navigate, but instead engage in unpredictable off-loading based on the multiple administrative identities (addict, patient, criminal, homeless) affixed to them. Rather than an attempt to manage dangerousness or risk, new forms of civil commitment like expanded conservatorships are better understood as desperate attempts to stabilize this circuit and assign a clear locus of bureaucratic responsibility for a given person.

Case and Methods

That the debates around long-term care, chronicity, and constraint are happening in *California* represents a particularly sharp reversal. Civil rights advocates celebrated California's

Lanterman-Petris-Short Act in 1968 as the "Magna Carta" (qtd. in Morris 2009:302) for the mentally ill. One appellate court judge at the time went so far as to claim that the LPS Act "promises to virtually eliminate involuntary hospitalization except for short-term crisis situations" (Bazelon 1968), a claim made by policymakers today out of frustration, not celebration. California's "civil libertarian, legalistic approach" (Aviram 1990:164) did make civil commitment much more difficult than in New York, where one psychiatrist who had exercised in both states told me, "California took a strong view. I mean, you can be dangerous as hell and you're going to spend just a couple of days in a hospital in California. It's very, very hard to get in, and it's very, very hard to stay in" (Interview, 12/6/16). Yet California law actually contains a particular, dedicated mechanism to get people to "stay in"—conservatorship—that has been barely studied.

At the same time, California was particularly aggressive in closing its state hospitals[12] and Governor Reagan's cuts to public mental health services are still frequently evoked as the death knell of a system of true community care in the U.S. (Torrey 2013:96). This combination of cuts and civil liberty constraints created a "characteristically extreme version" (Simon and Rosenbaum 2015:17) of de-institutionalization in the state. Even if today it has the second largest number of psychiatric beds in absolute terms, at 23.5 psychiatric beds per 100,000 people it is well below the national average of 33.1.[13] The California Hospital Association publishes a yearly report on the lack of psychiatric beds that begins with the statement, "California's crisis is not unique, but we fare far worse, comparatively."[14] California's decentralized county-based specialty mental health system serves only 1.6% of the population (versus a national average of 2.2%), less than half the proportion in New York (Figure 0.10). This bare bone system is now facing multiple sets of pressures: a number of homeless and substance-using clients above the national average (Figures 3.1, 3.2) and demands for it to serve the large number of persons leaving the state's prisons and jails.

The research for this chapter took place along three tracks. First, with the help of research assistants, I sought to understand how conservatorship was currently being used in California as a response to chronic mental illness. We tried to speak to actors who made key decisions at each step in the lengthy conservatorship process (Figure 3.3). The first part of this chapter follows this process focusing on four steps, each of which served to divert people away from conservatorship: admission to a hospital, application from the hospital and investigation of that application by the county conservator's office, hearing to determine the presence or absence of grave disability, and placement into an institution.

The second part of this chapter is based on our examination into why the long-term care placements into which conservatees were traditionally placed are diminishing. We connect this to countervailing policy initiatives to buttress this system and expand conservatorship. We focused on understanding how providers, advocacy organizations, and policymakers thought about the relationship between chronicity, long-term care, and constraint, and how these ideas were shaped by shifting evaluations of the relative mix of mental illness, drug use, criminality, violence, and economic precarity attributed to individuals targeted by conservatorship.

The largest portion of data for this paper comes from eighty-one interviews with key actors, focusing in particular on county conservators (usually trained as social workers) and public defenders from counties around California and a broader range of housing, outpatient, and hospital

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[12] According to Bardach (1972), the Department of Mental Hygiene was once the largest state agency after the University of California system. But from 1955 to 1974, spending on state hospitals dropped from 2.57% to .86% of the state budget (Scull 1977:73).

[13] Lutterman et al., *Trend in Psychiatric Inpatient Capacity*: 39.

[14] California Hospital Association. 2019. *California's Acute Psychiatric Bed Loss*. Sacramento, CA: 1.

Figure 3.1: Homeless Persons Among Public Mental Health Clients (2007-

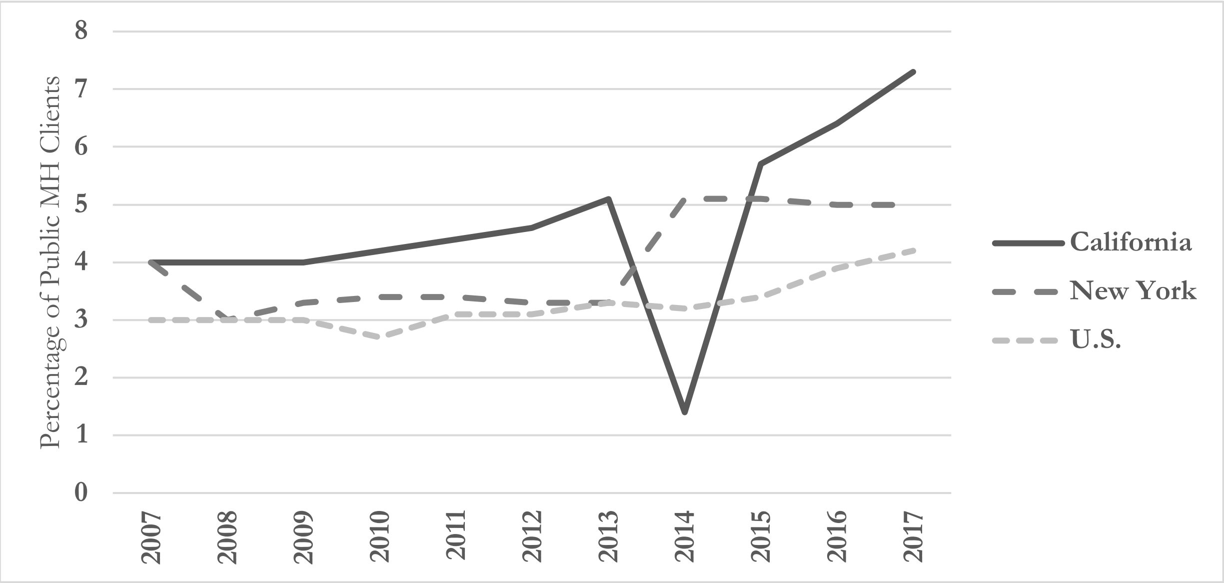
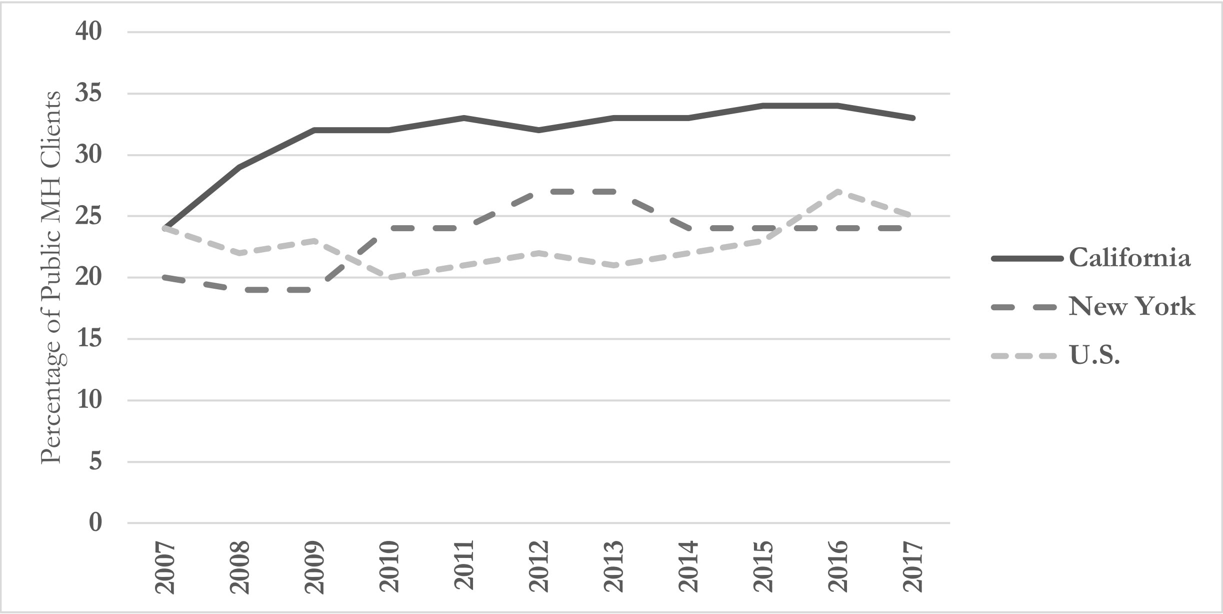


Figure 3.2: Co-Occurring Substance Use Disorders Among Public Mental Health Clients (2007-2017)

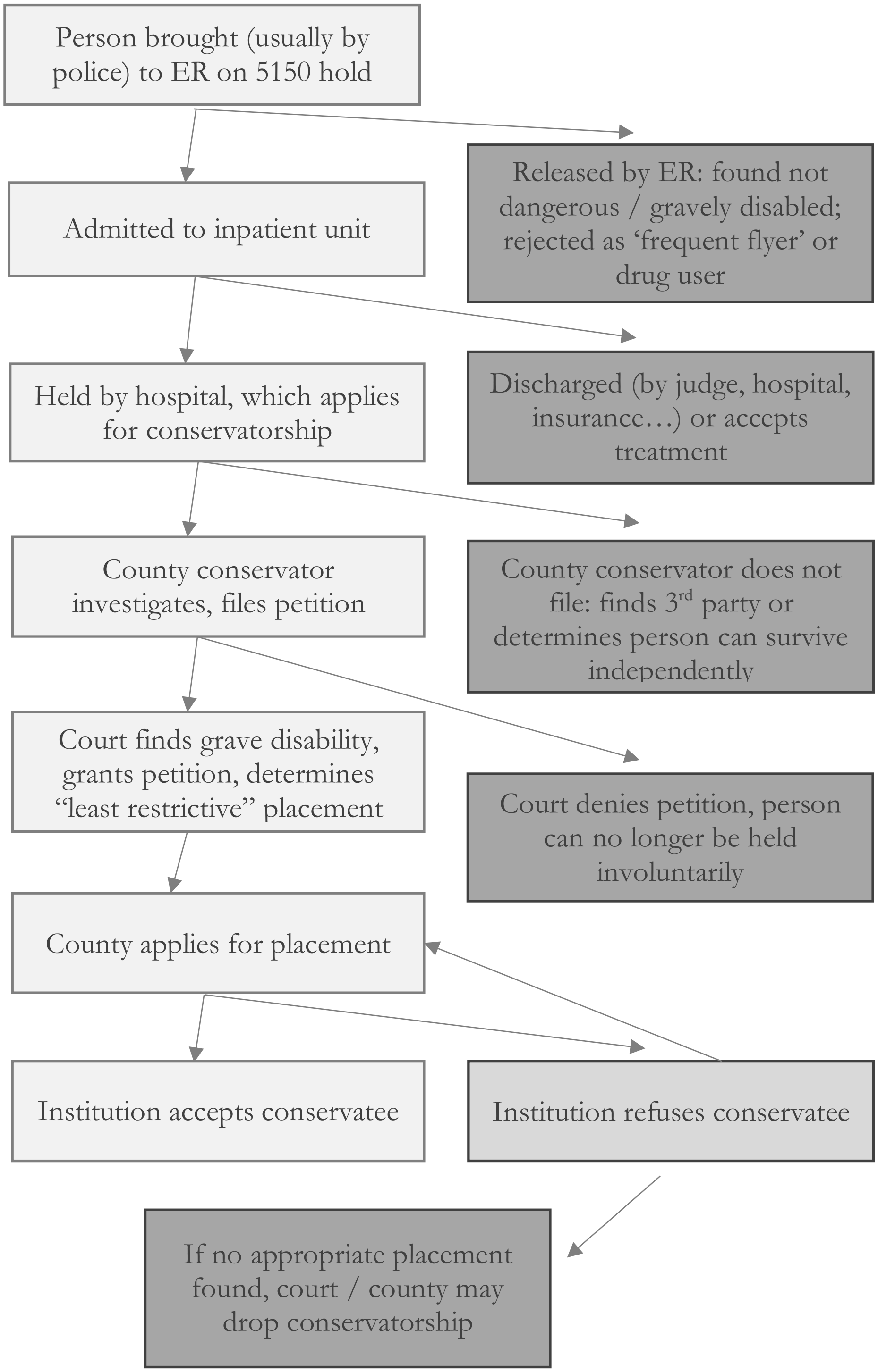


Source: SAMHSA Uniform Reporting System. Thank you to Didi Wu for compiling this data.

providers in Alameda and San Francisco Counties. We contacted around two-thirds of California's 58 counties to try to interview a representative from the conservator's and public defender's office. The response rate was around one-third. Some counties had no dedicated public defender for LPS cases or contracted out the cases to private firms that were difficult to reach. A significant number of county conservators seemed wary of external scrutiny and explicitly refused to participate. Similarly, two of the key institutions in mental health policy in San Francisco—the Department of Public Health and San Francisco General Hospital—did not respond to our inquiries.

We supplemented our interviews with multiple other qualitative data sources. Sierra Timmons performed an ongoing review of media around conservatorship reform. Kimberly Nielsen and Didi Wu monitored the creation of new locked facilities in California. Michael Long and

Figure 3.3: Conservatorship Process in California



Timmons observed some key hearings around mental health services in San Francisco. Yoshi Cohn and Amritha Somasekar looked at archival materials around conservatorship and mental health services in California jails, respectively. They all performed invaluable service in identifying, scheduling, carrying out, transcribing, and analyzing interviews.[15] Finally, this chapter is informed by my own observations with a clinical team that worked with some clients coming in and out of conservatorship and long-term housing, as well as my participation in working groups around long-term care organized by the California Behavioral Health Planning Commission.

Conservatorship in California: Halting the Merry-Go-Round?

Spinning through the Emergency Room[16]

Although the LPS Act allows for conservatorship referrals to be made from outpatient and criminal justice settings, every county said that at least 80% of applications came from acute care hospitals (some actually claimed that was the *only* setting they could come from). Usually the process started with a 72-hour hold (also known as a "5150"). The number of such hospitalizations in California has gone up, but the proportion of them that are converted to 14-day holds ("5250s") has declined slightly since 1990, to about 40%.[17] But the proportion of 5250s which last into a 30-day "Temporary Conservatorship" has plummeted from 23% to 3.5% over that time period. About 1.5% of people entering California acute-care hospitals will enter the conservatorship process (Figures 3.4, 3.5). After that, conservatorships can be renewed on a yearly basis: as such, the number of "permanent" conservatorships filed each year is somewhat greater. [18]

Understanding this change requires analyzing the layers of decisions that screen out many potential conservatees. Getting on conservatorship first requires getting through an emergency room. ERs are at once institutions that are both an institute of last resort required to treat all comers (Malone 1998) and tools for tightly controlling limited inpatient resources. If anything, their filtering role has intensified as California has lost 30% of its acute-care psychiatric beds since 1995.[19] As detailed in this section, the decision-making heuristics, professional identities, and categories of deservingness of ER clinicians combine to stop many potential conservatees before they went 'upstairs' to an inpatient unit.

"Grave disability" (GD) is one of three legal criteria for a 72-hour psychiatric hold alongside danger to self and to others, but it is the only one for conservatorship. Officially, GD means that a person "as a result of a mental health disorder, in unable to provide for his or her basic personal needs for food, clothing, and shelter."[20] The outpatient clinicians I observed and those I interviewed, however, told me that GD was rarely sufficient to get someone through an ER into an inpatient unit:

> *Clinician:* If I'm filling out a 5150, I have to check a box, and I'll almost always do danger to self or danger to others. Those are more likely to get them in than [GD]. [GD], they [ER doctors] are not impressed by that.
>
> *Interviewer:* Because they're strict about whether the person can provide 'food, clothing, or shelter'? Is being homeless a sign you can't provide for shelter?

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[15] All research assistants are undergraduate students at the University of California, Berkeley.

[16] This section has benefited, in particular, from an excellent memo on psychiatric emergency rooms written by Kimberly Nielsen.

[17] Note that some 5150s may not become 5250s because the patient shifts to a voluntary status.

[18] Confusingly, a document from the California Behavioral Health Planning Commission claimed that "there has been a voluminous increase in referrals for LPS evaluations and more persons placed on LPS conservatorships." CMHPS, *Adult Residential Facilities*: 16. I could find no evidence to substantiate this claim.

[19] Although the number has actually increased since 2012 CHA, *California's Acute Psychiatric Bed Loss*.

[20] California Welfare and Institutions Code. *CHAPTER 1. General Provisions [5000 - 5121]*. Retrieved May 7, 2019. (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5008).

Figure 3.4: Involuntary Short-Term Holds in California (1990-2015)

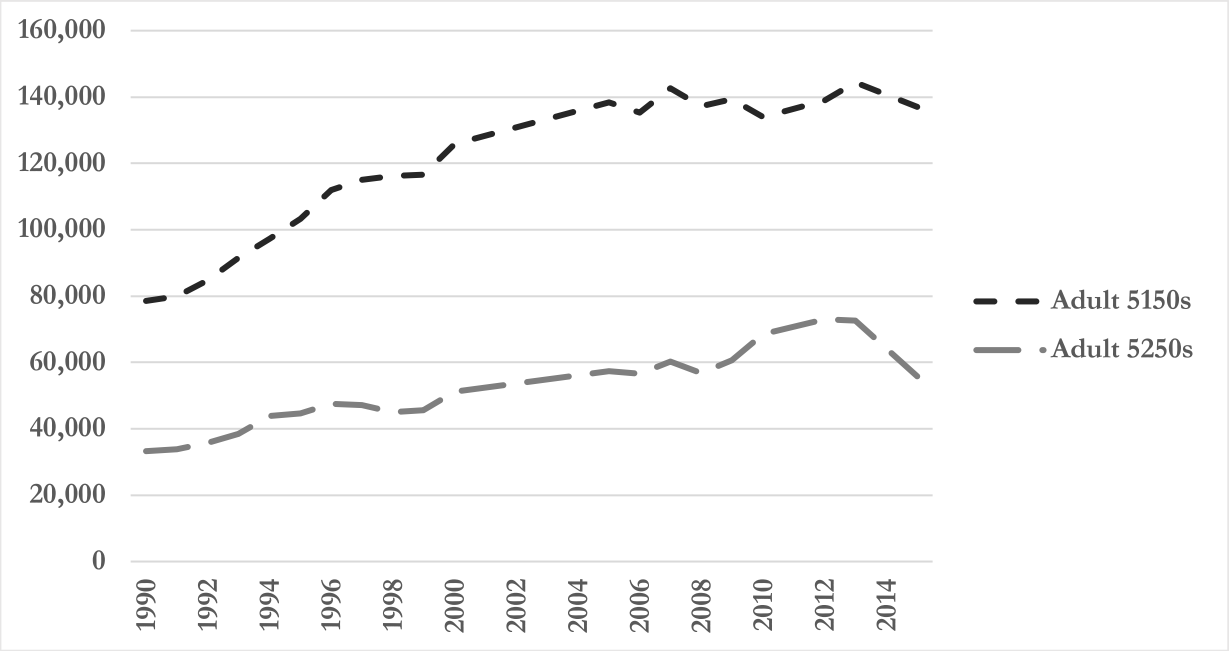
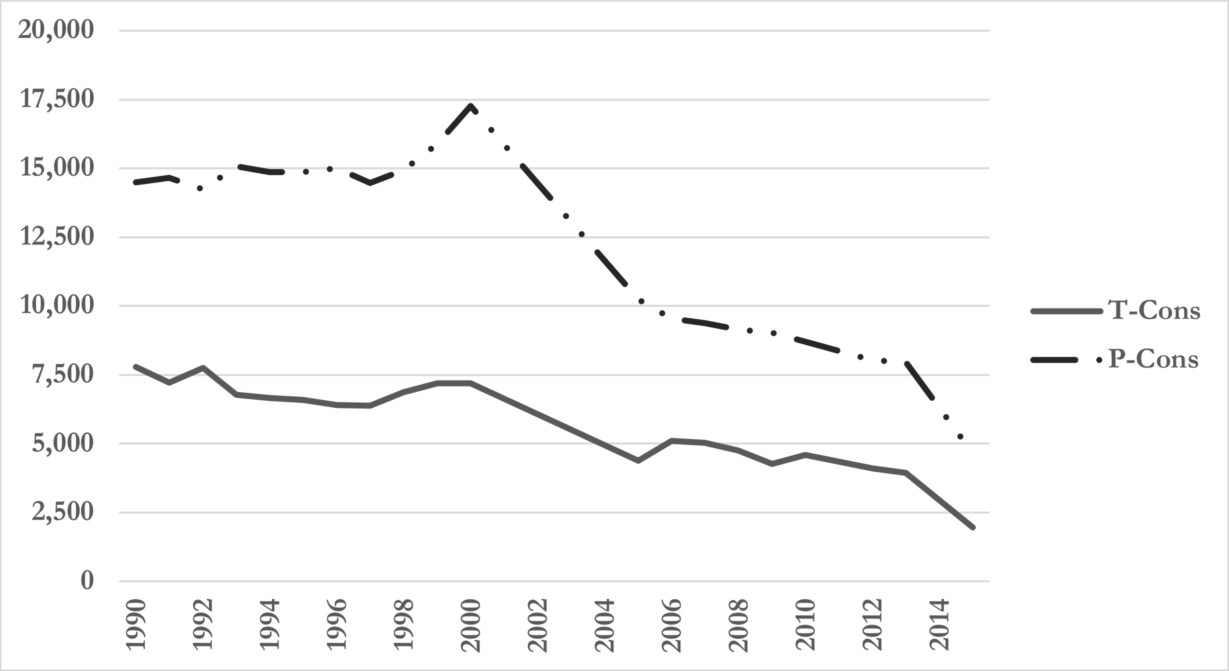


Figure 3.5: Conservatorships in California (1990-2015)



Source: California Involuntary Detention Reports.

> *Clinician:* Before I moved here, I would have thought that homelessness is not housing. But if the ER sees you have a backpack and a place in the park, that counts as housing. They [the ER] know that homelessness will not impress a judge enough to keep them, anyway (Interview, 2/19/19).

The skepticism of the judge towards GD as a reason for keeping a patient led ER clinicians to avoid using it as a criterion for an initial admission, which in turn led her to avoid using it to send someone to the ER—a sign of the chains of presumptions along the conservatorship pathway that could abort it from the very start. Another clinician noted, "When we're making the case to the ER, we always have to emphasize danger to self or others. Grave disability is getting more difficult, because there's no liability for the hospital" (Interview, 12/12/18). Clients were so acute by the time they were sent to the ER, one social worker claimed, "That pretty much every contact with the system is a trauma" (Interview, 8/4/17) because they quickly would be restrained and involuntarily medicated.

ER clinicians concurred, in their own way, that being incapacitated and incapable was not likely to move someone onto an inpatient unit. One triage nurse told me, "The best chance they have of getting attention is to have a crisis, start acting out and like yelling, screaming" (Interview, 10/19/18). Another nurse concurred, "The person that is sick in the corner, quiet, with a distorted reality of what's happening, keeping to themselves, they're not drawing any attention, and they're not getting any attention" (Interview, 10/20/18). A basic level of compliance, on the other hand, was an easy way out: "You take your meds cooperatively for twenty-four hours, you're not high because you don't have a pipe in front of you, and, boom, you're back on the street" (Interview, 4/18/18). Once again, acute dangerousness, rather than disability, was what cued doctors to patient need—even if the response to it frequently came in the form of mechanical restraints or an intra-muscular injection.

In rushing care towards those in the most visible crisis, clinicians reproduced the psychiatric hospitals' broader shift away from treating chronic patients.[21] As one inpatient psychiatrist explained, both managed-care insurance companies and hospital management were skeptical of patients who showed little sign of improvement and who would be difficult to discharge:

> Some of the things we run into are patients who live with a lot of suicidal thoughts. Ordinarily that's grounds to hospitalize them, but there are some people who always have suicidal thoughts, so it becomes a difficult judgement call of 'Are they suicidal enough they need to be in the hospital, or is the suicide ideation at baseline?'…Patients who are high utilizers, their insurance company says, 'They've been hospitalized here, here, here, here, here, here, here—for long periods of time. So I know you want to keep them for four weeks but, look, does it really make a difference?' (Interview, 12/9/16).

There was clearly a disconnect between the dispositions of ER clinicians, who saw themselves as offering rapid responses to extreme events, and patients referred by nursing facilities, Board and Care homes, or homeless shelters. They seemed to them like hopeless cases:

> Sometimes I'm like, 'Look, we can admit them, but nothing is going to come of this, admit them for five days under some bullshit excuse and at the end of the day what's going to happen?' It's not ethically fraud, I want do the right thing for that patient, but insurance could claim that it's fraud. They can shove it up their ass, if that's what I feel the patient needs then that's what I'm going to do. But that's essentially what it is—can I use this lie to try to help this patient? This patient doesn't want our help. You and I both know this person has no capacity. This person needs to be conserved, but it doesn't work that way; it takes them months to get conserved. We look at each other and say, 'We don't have another bed. They're going to get discharged one way or another.' After I've fought for these patients, I am beaten to the ground emotionally and mentally. To me a trauma case [for example, someone with a gunshot wound] is so easy, quick, know all the steps, works like a well-oiled machine. These cases, this is where my time effort and energy go (Interview, 4/6/18).

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[21] As one clinician told Rhodes (1991:55), "The good thing about emergency problems is that they end. If they don't end, they can be defined as chronic and sent on to someone else."

As the clinician explicitly detailed, the economic logic of both private hospitals and cash-strapped public ones dictated against admitting precisely those patients who were not acutely dangerous but needed a long stay to facilitate their entry onto conservatorship.

Two other screening mechanisms disfavored the population that policy-makers and advocates saw as needing conservatorship. Although thirty-three states allow for civil commitments for dangerousness or disability as a result of substance use, California is not among them (Christopher et al. 2015; Williams, Cohen, and Ford 2014).[22] For one thing, despite popular narratives that both mental illnesses and substance use disorders were "brain diseases" to be treated under a common rubric of "behavioral health," many mental health clinicians still saw the latter as out of their domain. Admitted one nurse, "I do want people who are addicted to drugs to have access to treatment. But I think there is this sort of like, 'That's not that we're here for'" (Interview, 10/19/18). Another ER clinician fumed, "Some of our patients have, you know, chest pain, broken bones, sometimes children, very significant injuries, and they're waiting because you've got this person who did a bunch of meth and is acting out" (Interview, 3/24/18). Beyond attributions of deservingness, clinicians had little motivation to admit clients who they perceived as high because the drugs would quickly clear out of their system, and the hospital would be obligated to release them—with none of the support systems that would help them avoid coming back. The clinical team I observed expressed their frustration at a meeting where they reported on a client who had "seven or eight suicide attempts" and who had been "jailed for assaulting a mental health worker." "How the hell is he not getting held?" one social worker asked. "Because he shows up at PES [psychiatric emergency services], he's high, and they let him go" (Fieldnotes, 9/17/18).

Finally, clinicians were wary of "frequent-flyers": persons who came to the psychiatric emergency room repeatedly for what clinicians perceived to be non-medical reasons. Doctors were well aware that police officers could send patients to the ER who they wanted removed from the streets but for whom they had no basis for (or interest in) arresting (Seim 2017). One ER nurse told us with annoyance, "Sometimes, the cops write a green sheet [the explanation for a 5150] and it's literally just a description of a homeless person: 'they're living behind CVS, their clothes are dirty.' We resent these kinds of patients because we want to be treating people" (Interview, 8/2/18). Patients themselves were co-conspirators in this burden-shifting from other professionals. A doctor reported, "It's very common with patients who are arrested, with criminal charges, and they'll complain of their chest pain, or that they're suicidal, because they know that they get to have a little detour" (Interview, 3/24/18). Another triage nurse recounted:

> We have people who come in and say, 'I just want to kill myself,' and they have no reason for why they want to do it. 'I don't know why, I just want to do it'…I mean, if someone who's saying that I want to end my life, then something has to be real, real terrible, right? But if they're a 'frequent flyer,' we're not going to keep them on a hold. Sometimes they'll throw a tantrum, and [the nurses will] agree we're going to ignore it. Everyone acknowledges it's fake (Interview, 10/20/18).

Chronically-ill substance users whose problems were an ambiguous mix of pathology and precarity were precisely those who conservatorship was supposed to target, and precisely the people that ERs were designed to keep out.

The use of emergency rooms as a short stop on the merry-go-round was, at least for some, functional. Outpatient teams described, for example, how clients who were unable to keep track of

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[22] California does allow civil commitments for "chronic alcoholism." Like other civil commitment statutes for substance use, it is rarely used: a conservator who worked in three counties over forty years said she never placed someone under conservatorship under this criterion.

their medication (sometimes for the obvious reason that they were homeless) could go into the ER to get a refill or injection, and then leave (Interview, 12/16/16). This use of ERs was not ideal but, with a fragmented and inaccessible outpatient system, neither surprising nor limited to mental health. But others saw private hospitals as engaged in what one 1949 editorial called "buck-passing [by] voluntary hospitals" that "prefer to dump all troublesome and expensive emergency patients on overworked public institutions" (qtd. in Hoffman 2012:80). With few "public institutions" like state hospitals, though, the new practice was just dumping, period.[23]

From Inpatient Ward to Conservatorship Investigation[24]

Reaching conservatorship required not just getting into a hospital but staying there long enough for psychiatrists to refer a case to the county conservator's office and for the county conservator's office to investigate and decide to file a petition with the court. In this respect, conservatorship was up against the broader reorientation of hospitals towards short-term, acute care. As described in Chapter 1, the resistance to managed care companies' pressures to reduce length-of-stay documented in studies in the '80s and '90s appears to have softened in California as well as in New York, as once nurse recounted:

> We had some very old-school psychiatrists for a while for whom, the utilization review people would say 'you've got to get them out,' and they would say, 'screw you, I'm going to keep them if I think they need to stay.' They've retired. Now we have, like, pizza parties for the unit that has the shortest length of stay (Interview, 10/19/18).

Although converting someone to a 5250 also triggered a patient's right to a hearing (similar to those described in Chapter 4 in New York), fiscal pressures were clearly determinative, as the medical director of a psychiatric hospital told me:

> Sometimes, you'll go to a 5250 hearing, and MediCal can refuse to keep you in the hospital based on acuity, even if the legal criteria are met. In this kind of a situation, you have a doctor, a judge, and maybe the person in the community who hospitalized the person who are all in agreement, but insurance isn't…Honestly, our length of stay cannot go down any further. Yes, the average is seven days, but that's pulled up by a very small number of people. 80% of our patients are here for four days (Interview, 4/2/18).

Moreover, once someone no longer met "acuity" and was simply waiting for a conservatorship petition to wend its way through the courts, the hospital started receiving MediCal's "administrative rate" per day, which was a few-hundred rather than over a thousand dollars per day (Figure 3.6).

The result was that hospitals searched aggressively to place their patients back with the institutions that may have sent them there in the first place, and who, in making that referral, may have decided that the patient needed the higher level of care offered by a conservatorship.

The clinical team I observed reported:

> We had a client who was mute, barely responsive, and not eating. The hospital let him go, and he couldn't talk. So when he got 5150ed again, we advocated higher up in the administration. We pointed out that not talking was not a sign that he was okay. That was dangerous. But he was already gone, so they said, 'well try again the next round' (Interview, 12/18/18).

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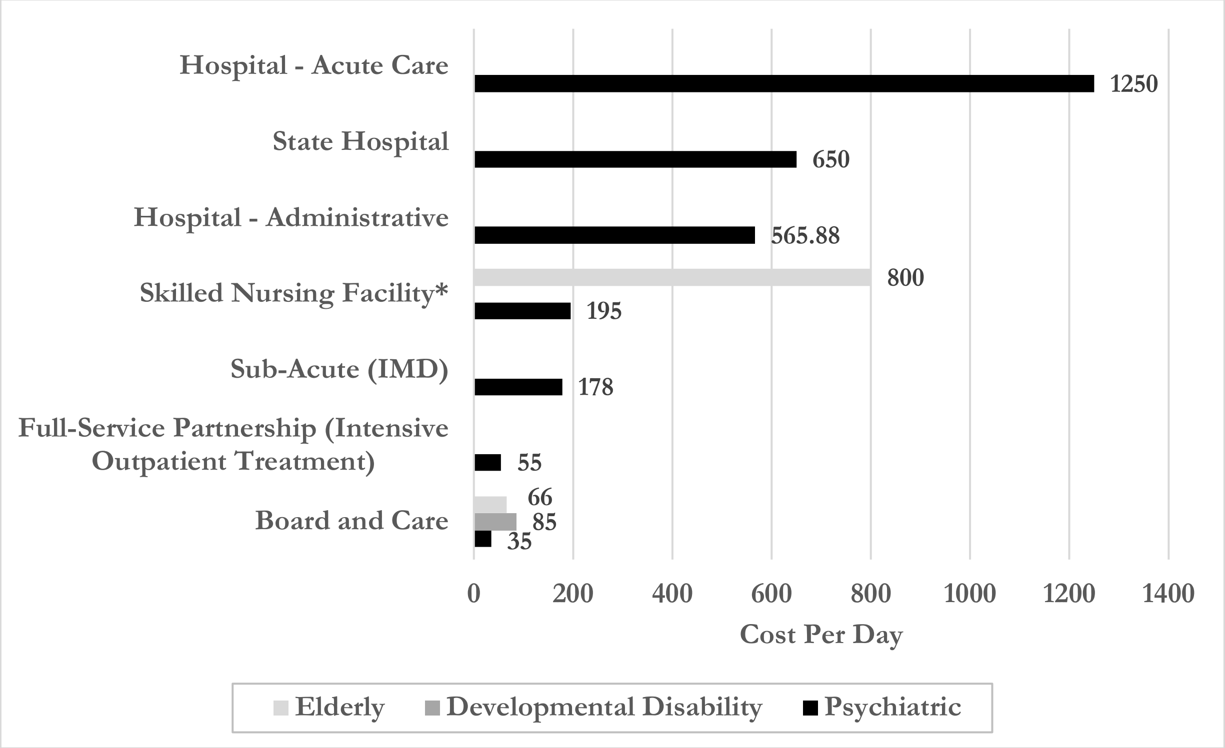
[23] A 2018 California law now requires that hospitals engage in more extensive discharge planning for hospitals, like documenting that shelters to which they were referring them actually had beds open. Hubert, Cynthia. October 9, 2018. "Homeless Patients Were Left on the Streets by Hospitals. This Law Could End 'Dumping.'" *The Sacramento Bee.* Retrieved May 7, 2019 (https://www.sacbee.com/news/local/homeless/article219683635.html).

[24] This section rests, in particular, on the hard work of Yoshi Cohn and Amritha Somasekar.

Figure 3.6: Estimated Payment Rates by Population and Facility Type in California ($ per Day)



* Based on the difference between Medicare/Medicaid rates available to the elderly and people with severe mental illness who are under 65.
Sources: California Department of Health Care Services; Kelly et al., *A Call to Action,* Lundstrom, Marjie and Phillip Reese. 2016. "Shifting Population in California Nursing Homes Creates 'Dangerous Mix.'" *The Sacramento Bee.* Retrieved May 9, 2019 (https://www.sacbee.com/news/investigations/nursing-homes/article69658602.html).

Another key form of offloading was back onto families. One county conservator reported, "We have families who say, 'The hospital called. They said I have to get him or he's going to the street.' It's scary. 'This person is your responsibility'" (Interview, 4/23/18). One inpatient psychiatrist admitted, "There used to be a requirement that we have a 'safe discharge plan' which meant finding someone a place to live. Patients ask for it. Now we say, 'that's not we do here.' We discharge people to the street all the time" (Interview, 12/2/16).

Ultimately, psychiatrists indicated that they filed conservatorship petitions when it was clear that all other available options had been tried, that trying again would be flagrantly futile, and the patient was still cycling through anyway. One inpatient psychiatrist explained:

> It [conservatorship] is for people who have failed at all lower levels of care. They've been working with an outpatient team, they've tried an Acute Diversion Unit, residential placement, tried to live independently, and repeatedly come to the emergency room, and they just have trouble with medication compliance and they wind up in different cycles of care and don't seem to maintain outside of a structured environment (Interview, 3/12/19).

An outpatient provider who had recently had a patient finally move towards conservatorship concurred: "The only person we've had conserved was someone who we could not stabilize, and he was just ping-ponging from the emergency room to the community, then he'd go home, his mother would take him in, they'd fight, he'd leave… So finally they put him in an IMD [a locked sub-acute facility]" (Interview, 3/19/19).

Even if the hospital decided to apply for a conservatorship, they had to wait for an "investigation" by the county conservator's office, which would decide whether to pass the case on to the courts. No one we talked to became a county conservator out of a direct interest in guardianship for the mentally ill (most were trained as social workers). Instead, they usually fell into the role, joining an agency that was typically an appendix of the county department of mental health, human services, or aging. They frequently complained of being institutionally marginalized and operating with a budget that was relatively fixed, regardless of the number of people referred to them. Facing these pressures, investigations ruled out some clients out of hand. Conservators reported that they immediately discarded applications if the "mental disorder" cited seemed to be primarily a personality disorder or dementia; the former, because they thought conservatorship was going to be ineffective anyway, and the latter because it pertained to an often-separate office that handled guardianship for the elderly. As virtually everywhere else in the system, a perception that someone's problem was primarily substance abuse was also a disqualifier:

> We have some people who are primarily substance use, but if they haven't completely fried their brain, they're smart enough to get out of public conservatorship, because they know that means a locked placement, which means they can't use…So we try not to put those clients onto conservatorship, because they'll get our other clients in trouble and create issues (Interview, 4/24/19).

Conservators were also wary of an increasing (if still small) number of referrals from the criminal justice system, who for them did not fit their model of an appropriate conservatee. As one explained, "Just because you find yourself arrested a lot for misdemeanors—trespassing, failure to appear, urinating in public—and you're a nuisance to law enforcement…That's not what we're looking at for conservatorship" (Interview, 10/11/18).

Ultimately, though, even for people who were manifestly mentally ill, investigations still needed to ensure that the county conservator was being used as "the agency of last resort." One conservator explained that his office's investigations started by asking hospitals, "Have you tried to get them into housing and treatment? Have you done outreach? Have you hooked them up with shelters?" (Interview, 10/11/18). Like hospital seeking to discharge patients, conservators who wanted to avoid filing for someone often focused their efforts on finding family willing to take the person in. Even in the absence of family, shelter, or outpatient provider, conservators wanted to see that there was one last discharge plan that hospitals had tried before filing: nothing. One county explained, "Some people make it 'managing the homeless lifestyle.' It's their choice to be homeless, they know they're homeless, they've made the call. They may not be sheltered, but they're getting food somewhere" (Interview, 10/30/18).[25] Some of the advocates for expanding conservatorship, which I describe in the second part of this paper, recognized what an incredibly low baseline counted as functional in the context of a crisis of homelessness:

> I went to battle with a conservator once who said that their person was not gravely disabled because they were homeless but were street savvy enough to get food from a dumpster…I was like, 'Can they access resources to get them housing?' and they said 'Well, they have a tent.'…I have seen people diagnosed with schizophrenia wearing five jackets in 115 degree heat. Is that securing clothing for yourself? I think it's unreasonable, they think it's resourceful (Interview, 4/4/18).

Across the state, a strong civil liberties discourse emerged among conservators who seemed well-aware of the intense infringement of rights conservatorship entailed: "Doctors have this paternalistic

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[25] In general, conservators from rural counties seemed more willing to intervene for persons who were visibly "not making it" in the community.

idea, 'we want to protect people, we don't want them to hurt themselves,' but people have a right to make decisions, even if they're poor ones" (Interview, 12/4/18). Conservatorship was, by-and-large, not a tool for supporting better choices or developing "insight." It was a last, stop-gap measure for those who would otherwise die.

Hearings and 'The In-Family Defense'[26]

No state agency in California regulates, gathers data on, or publishes best practices for the use of conservatorship.[27] Formally, then, safeguarding the rights of potential conservatees depended on the courts, which receive and rule on the petitions made to them by the county conservator's office. At least at the appellate level, judges have insisted that conservatorship is an extreme deprivation of liberty:

> From the perspective of the person who resists this confinement, there is little to distinguish it from incarceration in a penal institution. Because the mental facility is authorized to administer drugs to him against his will, detention there might be considered more severe than confinement in a penal institution.[28]

Because long-term placement in a locked facility is "not any less involuntary because the state called incarceration by one name [civil commitment] than another [criminal imprisonment]," the courts have concluded that potential conservatees have a right to counsel and a jury trial, which must find unanimously that a person is gravely disabled "beyond a reasonable doubt."[29]

Rights, of course, have little meaning unless there is someone to vigorously advocate for them. Unlike in New York, where the Mental Hygiene Legal Services was specialized in representing the mentally ill (Shea 2012; Tartour and Barnard 2018), in California this role fell to the public defenders' office. The "LPS circuit" was clearly a low priority, as one attorney admitted: "I went part time because I had kids, so I wound up taking these cases because they're supposed to be easier, they call it the 'mommy track'" (Interview, 4/23/18). Another explained, "We're not really qualified to do this, and we're pretty isolated. Some counties say, 'If you've done a death penalty trial, you can take a break and do conservatorship'" (Interview, 4/25/18). "I've been banished here," another admitted, "because of office politics" (Interview, 2/22/19).

"Low status" is not necessarily the same as "low effort." Some public defenders had been specializing in these cases for a long-time and insisted, whatever their colleagues thought, that they were carrying the mantle for the public defenders' mission to advocate for the vulnerable. While previous studies on LPS cases found public defenders conspiring with district attorneys to keep their clients hospitalized (Holstein 1993; Warren 1982), public defenders generally claimed to follow a "stated interest" model in which they did what their clients wanted—including contesting conservatorship when they knew their clients needed it.[30]

They could do so confident they would probably lose anyway. Partly, this was because conservators indicated that they were, well, pretty conservative about filing: "We don't bring cases in

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[26] Special thanks to Michael Long and Sierra Timmons for their help with this section.

[27] Prior to the assimilation of the Department of Mental Health into the broader Department of Health Care Services, I was told, the state had someone who monitored the use of LPS around the state (Interview, 4/23/19). That position appears to have disappeared, although at the time of writing I heard about a new state audit of the use of LPS.

[28] *Doe v. Gallinot* (C.D.Cal. 1979) 486 F.Supp. 983, 991-992, aff'd, (9th Cir. 1981) 657 F2.d 1017.

[29] *Conservatorship of Roulet* (1979) 23 Cal.3d 219, 235. "Beyond a reasonable doubt" is a stricter standard than that applied in New York and in hearings to contest 14-day holds, "clear and convincing evidence."

[30] There is a potential bias in the data here. Some counties are too small to have a public defender's office at all, and some small offices contract LPS work out. Those counties where LPS work is particularly undervalued might be those least likely to respond to our survey.

front of the judge to say, 'ehh, it could go either way, he's kind of annoying the cops, so we filed'…I don't think we've ever lost a case" (Interview, 10/11/18). Appellate courts have deemed that conservatorships must be based on a person's *present* condition of grave disability.[31] In several counties, the public conservator and county counsel, their typical representative, indicated that they would file multiple 30-day "temporary" conservatorships, which did not require a hearing, before moving to a "permanent" one-year conservatorship. As a person lingered on an inpatient unit for weeks, often being forced to take medication involuntarily, it became harder to show that this housed, fed, and clothed person could not currently meet their needs for housing, food, and clothing. Explained one attorney:

> People just keep cycling through. One reason we have that cycling is that people who receive psychiatric medications often times get better and they do not then present as gravely disabled and they are not hold-able as per an LPS conservatorship. But once they're off the conservatorship, they stop taking medications, they decompensate, they're taken in on a 5150 and it starts over again. A lot of medication non-compliance gives rise to on-and-off LPS conservatorship (Interview, 11/16/18).

For public defenders, this interim period was actually their best chance to get a "win" for their clients, by convincing them that it was worth it to take medication, if only to get out of the hospital and to be able to stop taking them again. The universe of potential conservatees thus narrowed down to people whose conditions were so bad that their "baseline" was not functioning even when medicated and within the structured environment of the hospital.

As reported in the only recent research on conservatorship hearings (Morris 2009), public defenders told me that most went uncontested. Their clients were too sick from mental illness or too sick of the mental health system to want to come to court. Others submitted to conservatorship for a more basic reason:

> You would expect that if anybody is being told 'you're on a psychiatric hold…' [they would contest it] but if the alternative is 'I have nowhere to go, I need help finding housing,' or just generally, 'I don't have the support, I'm not doing well,' a lot of people are willing to stay when they're getting three meals a day, there's shelter, and nursing for their medical needs (Interview, 4/17/19).

For those that did fight conservatorship in court, successful clients might be those who showed a willingness to cooperate with treatment. For others, being able to articulate a plausible plan for survival despite their symptoms was enough. Reported a county attorney who represented the conservator's office:

> I win 95% of the time. I've only lost twice, and it was for the same person. He was the 'successfully homeless.' He was as crazy as crazy could be. He believed he was really from another planet. He believed there was a mechanical device in his chest that called him to do things he didn't want to do, he believed the president was Abraham Lincoln, but he could articulate very well how to get food. [He could say] that he has SSI [social security disability] and that he would budget and wouldn't buy Filet Mignon and run out of money. He was street smart. He was familiar with the shelter system, and able to articulate to the satisfaction to the jury that he could provide for food, clothing, or shelter.

The attorney seemed blasé about losing the case: "He's been in the system, round and round…We'll see him again" (Interview, 11/16/18). Some rural public defenders suggested that civil liberties and small-government libertarianism could be effectively aligned, particularly in jury trials: "We are in a more conservative, more Republican county here. Which means we maybe win more. 'This person

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[31] *Conservatorship of Benevuto* (1986) 180 Cal.App.3d 1030.

knows where the shelter is, they have the address of the food bank, why is the government involved?'" (Interview, 4/23/18).

For those clients who were in no state to explain how they would survive on their own, the best strategy for public defenders was finding a "third-party assist," usually from a family member. When California closed its state hospitals, the burden overwhelmingly fell not on community clinics or even Board and Care homes, but families (Padwa et al. 2016).[32] Families are inevitably at the forefront of calls to expand conservatorship. Their stories, like the one reported below, frequently anchored media stories in which conservatees themselves had little voice:

> For years, Diane Shinstock watched her adult son deteriorate on the streets. Suffering from severe schizophrenia, he slept under stairwells and bushes, screamed at passers-by and was arrested for throwing rocks at cars. Sometimes he refused the housing options he was offered. Sometimes he got kicked out of places for bad behavior. Shinstock…begged mental health officials to place him under conservatorship…But county officials told her, she said, that under state law, her son could not be conserved; because he chose to live on the streets, he did not fit the criteria for 'gravely disabled'…[He was arrested and] spent the better part of 15 months in solitary confinement, ostensibly for his own protection, and because he was unmedicated, his mental health 'deteriorated to an extreme degree,' said Shinstock. By this past January, he was so emaciated that he was unrecognizable, she said. Only then did the county agree to conserve him again. She doesn't know how long it will last this time.[33]

The article went on to explain how Shinstock became a vocal advocate for making it easier to conserve people like her son.

What the article did not suggest, however, was that she might herself be the barrier. Appellate rulings establish that "A person is not gravely disabled…if the person is capable of safely surviving in freedom with the help of willing and responsible family members, friends, or third parties."[34] Even if they were adversaries within a hearing, both public defenders and county conservators had a shared interest in finding (or creating) "willing and responsible" family members. Noted one attorney:

> The best way to get somebody off is third party assistance…Often, what will happen is someone will tell me maybe mom and dad or brother and sister will care for them. If I tell that to the Public Guardian, they're excited. They would try to make that happen, if the relatives will do it (Interview, 9/11/18).

The phrasing of "third-party" is revelatory. The search in hearings, as earlier in the process, was to find someone else to care for the potential conservatees (including the potential conservatees themselves). At issue in the hearings was not patients' "capacity" or "reason" or really even their ability to "make it" in society, but simply whether they could plausibly maintain themselves outside of the institutions currently confronted with them. The courts' orientation was strikingly different from that described in Holstein's (1993:146) now thirty-year-old study of commitment hearings in California, where judges were more likely to release patients if they had "institutional living arrangements" rather than "fragile independent ones." Fragile and independent, by and large, would do.

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[32] Davis et al. (2012) point out that there are more people with severe mental living with relatives than in state hospitals, residential-care facilities, boarding homes, and prisons and jails—combined.

[33] Wiener, Jocelyn. August 30, 2018. "Why Is It So Hard to Get Mentally Ill Californians into Treatment?" *CALmatters*. Retrieved May 7, 2019 (https://calmatters.org/articles/california-homeless-mental-illness-conservatorship-law/).

[34] *Conservatorship of Early* (1983) 35 Cal.App.3d 244.

Placements: The Tail That Wags the Dog

Alongside the ability to consent to medication on conservatees' behalf, "the principal power which the court may grant a conservator is the right to place conservatees in an institution," a power with the potential to create an "unbroken and indefinite period of state-sanctioned confinement"[35] so long as the conservatorship was renewed on a yearly basis by the judge. When LPS was originally implemented, nearly all conservatees were placed in state hospitals (Interview, 4/23/19). Today, however, conservatees frequently step down from the acute-care hospitals from which petitions originate to locked sub-acute "IMDs" [Institute for Mental Diseases] or unlocked Board and Care homes.[36]

In their order placing someone on a conservatorship, the courts specify the "least restrictive" alternative for that person. That, in turn, created a legal obligation for the conservator (usually in conjunction with the county Department of Mental/Behavioral Health) to find that kind of placement. Conservatorship was, one disability-rights attorney explained, a "two-sided coin: if you're going to take away someone's rights, then you have a duty to provide for them whatever the thing is they couldn't do for themselves." A court-ordered conservatorship was often the only avenue to get the system to mobilize to meet someone's otherwise unmet needs: she went on, "I've heard attorneys [public defenders] say 'It doesn't make sense for them to be conserved, but if they're conserved, that county is probably going to house them somewhere'" (Interview, 3/19/18).

For the most severe clients, that "somewhere" could still potentially be a state hospital. Traditionally, each county was allocated a certain number of beds and could rotate clients through at their discretion. Now, as one county conservator explained, "They get in line behind every other county" (Interview, 7/7/17), making wait times (and therefore, costs) unpredictable. An inpatient psychiatrist expressed her frustration:

> The way it trickles down to us is, we're going to start doing these weekly meetings [with hospital management] to really assess the patient's necessity for being in the [acute care] hospital and we're going to bring in the transitions team, which is they're like, they're part of the [county] Department of Mental Health and they're supposed to be helping with people going to discharge, all these other places. So someone comes in, it's always like, it's ridiculous because they don't have any news for us. 'He's number forty-two on a Napa [State Hospital] waitlist—well, he was forty-two like three months ago' (Interview, 9/10/18).

92% of California's 6,700 state psychiatric beds are now allocated for forensic patients, such as those found not-guilty by reason of insanity, incompetent to stand trial, or transferred from state prisons.[37] As such, for conservatees who were not violent and not charged with any crime, but simply chronically ill, state hospitals were nearly a non-option for placements.

In most cases, then, conservators were looking for a bed in a private facility, with the court referral, client's social security check, and some limited funds from the county in hand. One county conservator described the scenario: "There are people out there that need conservatorship. But it's not a magic wand. We don't have any independent money. It's just what the client has. There's no placement money. We aren't the gatekeeper for the locked facilities" (Interview, 3/12/18). "Locked facility" in this case usually meant an Institute for Mental Disease, a high-structured specialized facility with less-intensive treatment than an acute care hospital. The label "IMD" referred to the

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[35] *Conservatorship of Roulet* (1979) 23 Cal.3d 219, 235.

[36] In some counties, a smaller number could remain on conservatorship temporarily while trying out less-structured supporting housing.

[37] Wik, Amanda and Vera Hollen. 2017. *Forensic Patients in State Psychiatric Hospitals: 1999-2016*. Alexandria, VA: National Association of State Mental Health Program Directors.

"IMD-Exclusion" in Medicaid, which barred federal funds from going to 16-plus bed psychiatric institutions. Counties thus had to pay for IMD placements out of general funds. Because beds were limited and counties were willing to pay different rates, IMDs could pick and choose:

> We tried to get a contract with [IMD]—it has a real recovery model, they care about their clients, and we got my boss [head of the county Department of Health and Human Services] to take a tour. But we didn't get it, because we don't pay as much as other counties. We lost six beds in the last year, and it was very clear that it was because [Large County] paid more…We are completely at the mercy of the operators (Interview, 4/24/19).

For small counties with just a few hundred-thousand dollars per year to pay for placements for all their conservatees, an IMD level of care might simply be "prohibitively expensive" (Interview, 1/24/19). Counties could also be outbid even for facilities within their borders:

> Our county has only one locked institution, and that institution has maybe 120 beds. We only get four of them. So the rest of our people go out of county, away from their family and friends, away from their support system, into an environment and climate that's totally different. It's not great (Interview, 4/25/19).

For smaller rural counties, 100% of their conservatees would be placed elsewhere; even larger counties, though, might send clients "as far north as Sacramento, and as far south as Long Beach" (Interview, 10/11/18).

Locked IMDs catered almost exclusively to conserved clients (Interview, 4/2/18). For slightly less gravely-disabled cases, conservators might attempt to place them into a Board and Care home. As discussed in the next section, these facilities were closing rapidly or converting from serving a mentally-ill to a developmentally-disabled clientele, giving the remainder more and more prerogative to be selective in who they would admit. As one report noted, "Due to the limited amount of Board and Care Homes, providers may be less likely to accept individuals with more intensive needs" as a result of the "availability of individuals…who are relatively easier to serve."[38]

Conservators were thus struggling to place the shifting mix of people who, for all their screening processes, still wound up on conservatorship. Subsequent to court rulings which cited, among other things, an absence of mental health treatment for prison inmates, California has been reducing its prison population by transferring these individuals to counties (Cooper 2013). Counties, in turn, were pushing an "enormous shift of criminal justice cases over to conservatorship," even though "we're not prepared for these types of individuals, we don't have the skill-set" (Interview, 3/12/18). Above all, a county conservator reported, they didn't have the placements:

> We definitely see people with more and more criminal involvement. Moreover, the people we're seeing are sicker and sicker. We're seeing a lot more assaultive type behavior, a lot of substance abuse on top of the mental illness, which compounds everything. Some have a combination of all three: mental illness, substance abuse, and criminal justice involvement. So it seems like the cases are getting more and more difficult, and that means that sometimes they're getting harder to place (Interview, 10/11/18).

One Board and Care operator explained why she was reticent to take people with a history of criminal justice contact or violence:

> We have a client we accepted who had a history of being AWOL from a couple of facilities. She was screened by our program, and we thought 'that was her past, but she said she wouldn't.' We met with her three or four times, she signed a program agreement, and we didn't think that because she did it in in the past she must do it in the future…But a few

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[38] Research Development Associates. 2019. *Yolo County Board & Care Study*. Health and Human Services Agency: 7.

> months later, she signed out, she didn't come back, she went missing for two days, she had done drugs, and then she was at the hospital. Community Care Licensing [the state regulator] wrote us up with a huge fine. So if we lose our appeal to them, we will no longer take the Jane Doe's with this history, and people are going to stay in locked facilities longer than they should (Interview, 2/27/18).

For county conservators, push back from Board and Care homes intensified their push back against the acute-care hospitals, county supervisors, or police departments who wanted them to conserve potentially dangerous or violent persons. Noted one, "Some of these clients, if I try to get them conserved and place them, it could jeopardize *all* our placements" (Interview, 3/20/19), because operators might choose to maintain contracts with other counties instead.

One endgame in the case of difficult-to-place conservatees was to go back to the courts. A public defender explained her current work for a client lingering in a hospital:

> I can demand a placement review. Essentially, I can request the court to hold the Department of Mental Health and County Conservator in contempt for violating the court order by putting someone in a locked facility, because the judge determined that person's least restrictive option is a Board and Care, and they're not in it (Interview, 4/23/18).

Frustrated judges might look at the situation, and ask, "What are you going to do with these people if I conserve them? You're not providing the necessary services!" and throw out the case. The issue, a state disability rights advocate noted, was "not about the legal standard… it's the mental health system" (Interview, 3/19/18).

It is here, at the very end of a long chain of steps intended to stabilize the institutional trajectory of the most unstable and chronically mentally ill, that its failings became most visible. The inability of the legal mandate of conservators to overcome the private prerogatives and financial interests of private providers flowed upward through the system. I asked the head of a small county's behavioral health department if a lack of placements explained a dramatic downturn in the number of people conserved, and he replied:

> It's crass but it's true. There's a lack of beds. There aren't the resources. The beds that do exist are incredibly expensive. When an individual becomes conserved, the [county] Behavioral Health Department is responsible for those costs. Someone in one of those placements could eat up the budget for dozens of other clients" (Interview, 3/26/19).

Explained a conservator, "Everyone in the system has referral fatigue. Everyone realizes, 'we send in plenty of referrals"—for hospitalizations, for conservatorships, for placements—"and it doesn't work" (Interview, 8/4/17).

Of course, thousands of people in California are still conserved. To an extent, the multiple sieves through which they had to flow centered the system on those who most clearly belonged nowhere else: the most severely and chronically mentally ill. For them, the goal of conservatorship was to eventually get them to "stay out of institutions and stay alive" (Interview, 4/2/18). But this system strained out people whose primary—or at least, co-occurring—problems related to drugs, violence, homelessness, criminality, physical health, or aging. These were precisely the individuals that stakeholders outside the mental health system most wanted to see it addressing, as discussed in the next part of this chapter.

Legal Constraint: A Patch for Housing and Homelessness?

Saving 'Shitholes': The Crisis of Long-Term Care

The absence of state-wide data on Board and Care homes (sometimes called "Adult Residential Facilities," or "ARFs") is indicative of the care with which policy-makers have treated them.[39] The California Behavioral Health Planning Council carried out a survey to which 22 (out of 58) counties responded and found that 783 ARF beds for the mentally ill had been lost in "recent years."[40] At the Sacramento forum on ARFs I attended, however, a presenter claimed that 10,687 beds, or about a quarter of the state's stock, had closed in just five years (Fieldnotes, 4/18/19). The disparity was explicable, as a representative from the licensing agency told me, because "we keep data on the kinds of facilities, but we don't really know who is in them. So if they're geared towards a certain population [the mentally ill or the developmentally disabled, for example] we wouldn't know" (Interview, 3/2/18).

The state Behavioral Health Planning Council kicked off its initiative on ARFs at a community forum in a public library in a suburb of Sacramento. The coordinator started the event by declaring, "We are really at a crisis point in developing community-specific full continuums of care for residential treatment." As she noted, "We were approached years ago because the operators were closing facilities. They are businesses after all." She admitted, "I know ARFs are not popular. They leave a bad taste, but there are some good ones…Permanent supported housing is not enough for some people." The notion of "continuum" was almost ritualistically evoked throughout the day (Fieldnotes, 1/26/18). It captured the precarious perch of their residents. On one hand, people were usually referred to ARFs by locked facilities in order to step them down: in their absence, they either lingered there or were discharged "creat[ing] a 'revolving door scenario,'" as one consultant put it.[41] On the other hand, once in place, residents were "one step away from homelessness" (Interview, 4/4/18).

The economic pressures on Board and Care homes were evident. Residents in Los Angeles paid a "rent" in ARFs of $35 a day, coming from social security disability (leaving them with $134 a month for "incidentals"). Some counties also paid a small supplemental "patch." With that, ARF staff were by regulation responsible for providing "lodging, food service, care and supervision, assistance with taking medications in accordance with a physician's order, assistance with transportation to medical and dental appointments, planned activities, housekeeping, laundry service, and maintenance or supervision of cash reserves."[42] For smaller facilities, this model rested on the herculean efforts owner-operators, often immigrants. An article described the travails of a Filipino immigrant who had initially opened a home for her daughter (who had multiple-sclerosis):

> To stay open, she has reduced paid staff from four to one. She and her ex-husband and kids handle shopping, cooking and medications. She washes the laundry at night when utility rates are cheaper, buys food in bulk on sale, and said she hasn't taken a real vacation in 40 years…'We're pinching pennies,' she said. 'I make a joke all the time: We're the cheapest hotel in town.'[43]

Still, according to a sample budget put out by the Planning Commission, a 13-bed facility for the mentally ill would now lose $255,668 per year based on rising costs for staff and regulatory requirements. In a booming housing market, owners had an easy way to get out and finally take a vacation. As one inpatient psychiatrist in San Francisco recounted, "These were kind of homegrown family businesses, with a mission to treat folks, but I know one person who sold his house [to someone who was not using it as a Board and Care] for two-and-a-half million and retired. You can't

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[39] A pending Assembly Bill, AB 1766, would require the state to track the different populations in ARFs.

[40] CMHPC, *Adult Residential Facilities*.

[41] RDA, *Yolo County*: 7.

[42] Kelly et al, *A Call to Action*: 5, 7.

[43] Wiener, Jocelyn. April 15, 2019. "Overlooked Mental Health 'Catastrophe': Vanishing Board-and-Care-Homes Leave Residents with Few Options." *CALmatters*. Retrieved May 9, 2019 (https://calmatters.org/articles/board-and-care-homes-closing-in-california-mental-health-crisis/).

deny folks the opportunity to do that." But, he noted, "that means people who are on conservatorships [and in a hospital] have to wait much longer to get in somewhere" (Interview, 3/12/19).

This "meagre reimbursement" for services, the report from LA noted, "does not provide any type of therapeutic enrichment, community-building, or case management"[44] for residents. In fact, the report described an 80-bed facility in which 70% of residents—all of whom were identified as "non-ambulatory mentally ill"—were receiving no therapy. 50% had been there for more than 5 years. At numerous working group and community group meetings I attended, advocates wrangled over whether discussions over home "quality" had any place in efforts to shore up their "viability" (a parallel to conservatorship, which was designed to ensure bare survival above all else). At one forum, a woman who identified as "the mother of an adult son who has been in a six-bed Board and Care for years" stated:

> 6 men in residential home and I'm the only family member coming in on a regular basis, which is once a week. It kind of shocked me. I've caught them making mistakes on medication…There's no privacy, there's no dignity. Those are basic human elements that are being stripped (Fieldnotes, 1/26/18).

A county ombudsman responsible for responding to complaints about facilities told me:

> There's not a lot of good options. We tend to see people who cycle between a locked facility, then they get better and are taking their medications, so they get released to an Adult Residential Facility…and at the SSI rate, they're just absolute shitholes. They're just atrocious. Part of it is, they really aren't getting enough money to do much better…we see poor food quality, lack of any activity, all kinds of social issues…People beating each other up, issues with medications not being managed or dispersed appropriately, sexual assault, buildings that are in absolute disrepair. We had one facility with so many roaches, the floor looked like it was moving. The bedbugs, scabies, those kinds of communicable diseases, bugs are rampant (Interview, 4/4/18).

The head of a clinical team that served mostly homeless mentally ill admitted to me, "We're fighting really hard to get our clients into substandard housing. And even those facilities get to pick and choose who they'll take" (Interview, 12/18/18).

Still, numerous informants told me that, subsequent to very high-profile failings—like a murder-suicide in which four disabled residents of a Board and Care home died when its owner set it on fire[45]—state regulators were intensifying their oversight (Interview, 2/20/19). With no attendant increase in payment rates, though, this further disincentivized ARF owners from taking individuals with an expensive mix of mental illness, substance use, medical complications (frequently, diabetes as a result of anti-psychotic medications), and problematic behaviors (like a flight risk) that exposed them to additional liability. Some of these complex cases were going to a growing "Wild Wild West" of unlicensed facilities that "could be putting twelve people in a garage," as reported by a family advocate in one meeting (Fieldnotes, 4/18/19).[46] "We had one of these unlicensed facilities that was padlocking people having a psychotic break in the back of the house," an investigator told me (Interview, 4/4/18).

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[44] Kelly et al., *A Call to Action*: 5, 7.

[45] Esquivel, Paloma. September 27, 2016. "5 Men Died in a Fire at a Home for Disabled Adults. Their Families Ask: Why Didn't They Get Out?" *Los Angeles Times*. Retrieved February 20, 2018 (http://www.latimes.com/local/lanow/la-me-ln-temecula-fire-20160927-snap-story.html).

[46] These facilities were also able to lure away some (non-conserved) residents of ARFs by the promise of allowing them to keep more of their social security checks.

A final set of pressures came from the conversion of places previously given to the mentally ill towards people with developmental disabilities. The financial logic of doing so was so obvious that it is surprising it hadn't happened already: in L.A., services to the latter group could be reimbursed at $85-110 a day through direct state funds, rather than $35 via social security.[47] Lamentations on this point reproduced a long-standing division between advocates for these two populations (Bagnall and Eyal 2016): "Why is there such a difference? We [the severely mentally ill] don't have as much cachet [as people with developmental disabilities]. The advocacy is better. The population is smaller. The needs are more stable. And the onset is earlier; they're not being blamed for it" (Fieldnotes, 4/11/19). A government-affairs specialist for a large Board and Care home with a positive reputation told me:

> This is anecdotal, because we don't have any data, but the Regional Centers [state agencies responsible for placing the developmentally disabled] come in and say, 'Hey, take our people.' So [the ARF] evicts the person with schizophrenia and moves in someone with an intellectual disability. $1026 a month for mental illness, $4000 for an intellectual disability. I don't blame them. They're still serving someone (Interview, 2/27/18).

Ultimately, the debates over the future of ARFs reproduced many of the themes around conservatorship. Public authorities were struggling hardest to find placements for people who checked multiple boxes, while facilities wanted people who checked just one.[48]

The Homeless 'Hamster Wheel' in San Francisco[49]

Despite ubiquitous media narratives of an endless homelessness crisis, the yearly "point-in-time" count of San Francisco's homeless population barely budged from 2013 to 2017, resting at around 7,500.[50] From 2017 to 2019, though, it jumped 30% to nearly 10,000.[51] Beyond this quantitative increase, though, there has been a sense of a qualitative decline in the condition and behavior of unhoused persons. The New York Times described it as the "land of the living dead," a place covered in "heroin needles" and "pile[s] of excrement" that "bring to mind any variety of developing-world squalor."[52] Between 2012 and 2017, 911 calls from residents for homeless complaints nearly doubled and 311 contacts for "homeless concerns" jumped eight-fold.[53] This section outlines how the trends in long-term care and conservatorship described in the first part of this paper intermingled with concerns about drug use and housing in a way that provided a sense of urgency for new political initiatives to expand conservatorship, described in the next section.

By all accounts, the declining availability of long-term care statewide was particularly acute (or perhaps, chronic) in San Francisco. A City Auditor's report found a 29% fall in the census of nursing homes and a 37% drop in Board and Cares between 2010 and 2015.[54] The reasons why operators were quitting the business in the city should be obvious:

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[47] Kelly et al., *A Call to Action*: 4.

[48] Even people with developmental disabilities become extremely hard to place once they are identified as having "co-occurring" mental illness (Interview, 4/17/19).

[49] Sierra Timmons and Michael Long provided helpful ethnographic data for this and the following section; Timmons also conducted an analysis of media reporting on conservatorship reform.

[50] Applied Survey Research. 2017. *San Francisco Homeless Count & Survey*. San Francisco, CA.

[51] City of San Francisco. "Homeless Population." *City Performance Scorecards*. Retrieved July 18, 2019 (https://sfgov.org/scorecards/safety-net/homeless-population).

[52] Fuller, Thomas. October 20, 2018. "Life on the Dirtiest Block in San Francisco." *The New York Times*. Retrieved May 10, 2019 (https://www.nytimes.com/2018/10/08/us/san-francisco-dirtiest-street-london-breed.html).

[53] Herring, Chris. "Complaint Oriented Policing: Policing Homelessness in Public Place." *American Sociological Review* (in press).

[54] San Francisco BLA, *Performance Audit*: 84.

> Larry Mateo, 59, once operated five board-and-care homes in San Francisco. By the end of last year, he'd closed them all. Now one is for sale and two others are being rented to young people—'they call them millennials'—who can pay the high rates commanded in the city. 'That's an easy no-brainer decision,' Mateo said. 'I don't have payroll, I don't have to go buy groceries, I don't have to deal with clientele.'

The article noted that some of his residents refused to leave. As the owner opined, "We had to call the sheriff to move them out because they just didn't want to move. I'm not sure if it was part of their mental illness, but they didn't want to adapt to change. They said, 'This is my home. Why are you moving me out?'"[55] The Chronicle's editorial board, calling for preserving the Board and Care system, offered an easier explanation for the reticence of residents to leave: "Many of their clients came from homelessness and are falling back into it when the board-and-care closes."[56]

An absence of in-city long-term care meant that, according to the county conservator's office, 70% of SF's conservatees were placed out of county (Interview, 8/4/17). Meanwhile, the city's "acute care hospitals [were] assuming significant costs" to care for those individuals who could not find a Board and Care or other step-down facility.[57] At hearings on mental health and homelessness, supervisors repeatedly expressed their frustration that the Department of Public Health could not provide consistent information on the time that hospitalized patients waited for a lower-level placement (Fieldnotes, 3/14/19, 5/1/19). But the department did report that, of 29 conservatees for whom petitions had recently been filed, 22 had been waiting on inpatient for 60 days or more. A public defender representing conserved clients told me that, on the day of our interview, he was visiting hospitalized clients who had been stabilized for seven and nine months (Interview, 4/17/19). The city's Auditor found that over the course of one month the city referred thirteen people to state hospitals, twelve to rehabilitation facilities, and ten to nursing homes—all of whom went onto a waitlist.[58] "That's why we're spending $21 million a year on unreimbursed administrative care," a supervisor fumed, noting that the county could not recoup from Medicaid the costs of still hospitalized but stabilized patients (Fieldnotes, 5/1/19).

Indeed, chronically-ill but un-placeable persons with mental illness were taking up the lion's share of a shrinking number of hospital beds (see Figure 3.7). The number of acute psychiatric places in San Francisco General Hospitals shrunk from 80 to 20 from 2001 to 2016, a period where the hospital was receiving a $75 million infusion from the Zuckerbergs. In something of a boiled-frog phenomenon, the shift seemed to only attract the SF Chronicle's attention when there was "a guy outside [the newspaper's office]…ranting to the sky."[59] Facing the unappealing prospect of patients lingering at low rates of reimbursement, Sutter Health eliminated 32 private psych beds when it took over one city hospital. It did not plan to include any in a new facility it was building: according to its spokesman, "needs are best met through a comprehensive set of community resources."[60] As one nurse complained, "In San Francisco there are few places to discharge our

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[55] Wiener, "Overlooked Mental Health 'Catastrophe.'"

[56] Chronicle Editorial Board. April 16, 2019. "Editorial: California Must Save This Source of Housing for the Severely Mentally Ill." *The San Francisco Chronicle*. Retrieved April 26, 2019 (https://www.sfchronicle.com/opinion/editorials/article/Editorial-California-must-save-this-source-of-13773024.php).

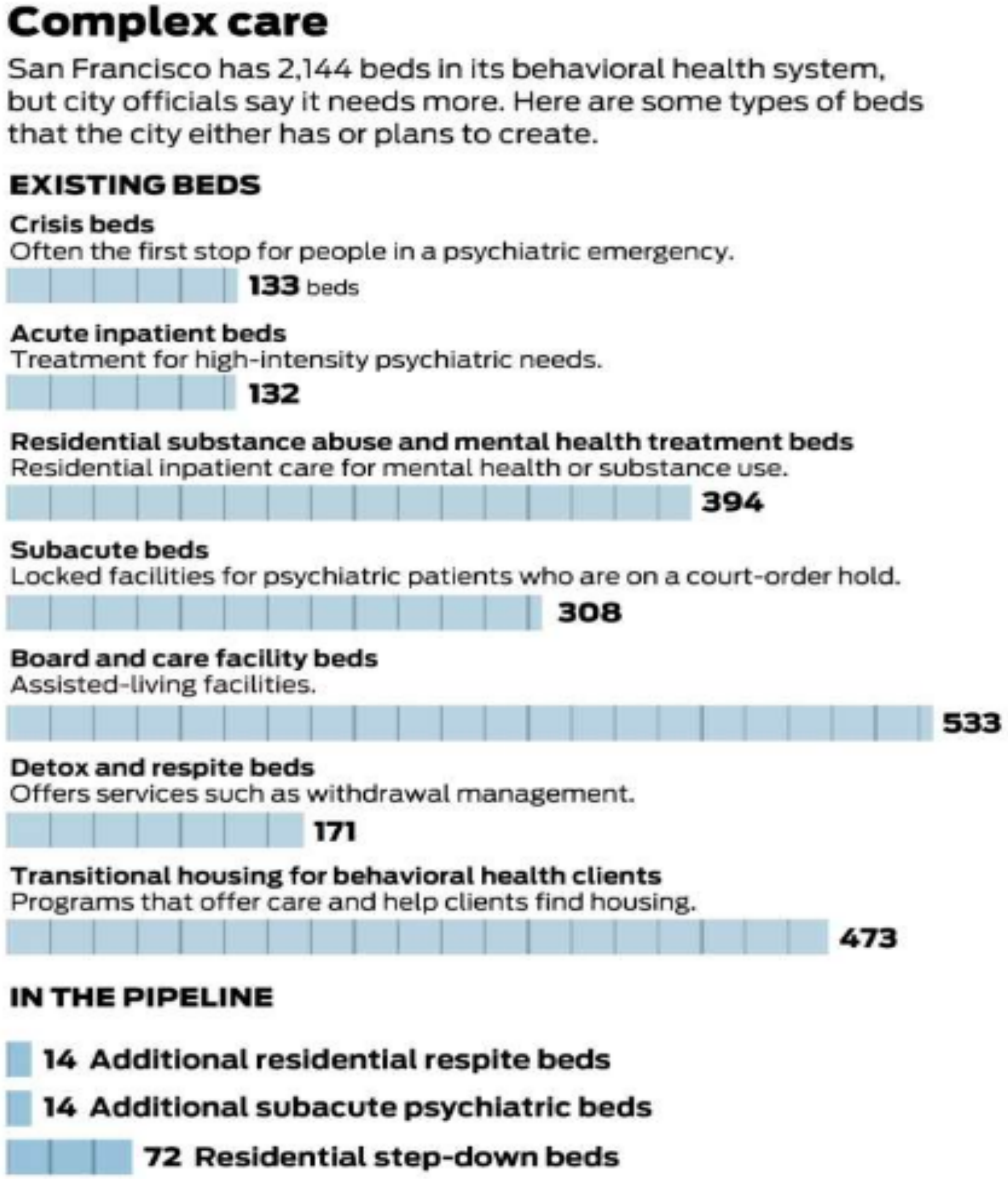
[57] Post-Acute Care Project. 2016. *Framing San Francisco's Post-Acute Care Challenge*. San Francisco, CA: Department of Public Health: 35, 32.

[58] San Francisco BLA, *Performance Audit*: 48-49.

[59] Nevius, C. W. March 3, 2016. "SF Hospital Services for Mentally Ill Suffer Drastic Cuts." *The San Francisco Chronicle*. Retrieved May 9, 2019 (https://www.sfchronicle.com/bayarea/nevius/article/SF-hospital-services-for-mentally-ill-suffer-6866700.php).

[60] Ibid.

Figure 3.7: Behavioral Health Beds in San Francisco



Source: Thadani, Trisha. April 12, 2019. "Fixing San Francisco's Behavioral Health System Is Complicated — Here's Why." *The San Francisco Chronicle.* Retrieved April 26, 2019 (https://www.sfchronicle.com/politics/article/Fixing-San-Francisco-s-behavioral-health-system-13761497.php).

mentally ill patients, few facilities with room where they can't do harm to themselves or others…We have patients stay…for many months awaiting placement or worse, they return to the streets without access to food, shelter, or other basic needs."[61] By her reckoning, even the gravely disabled were getting dumped.

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[61] Brizzolara, Meg. April 24, 2019. "SF's Psychiatric Services Have Been Cut to the Bone." *The San Francisco Examiner.* Retrieved May 9, 2019 (https://www.sfexaminer.com/opinion/sfs-psychiatric-services-have-been-cut-to-the-bone/).

The inaccessibility of acute-care and sub-acute beds flowed through the system in predictable ways. In fiscal year '16-'17, only 9% of the 6,704 people brought to SF General's Psychiatric Emergency Services (PES) were admitted into the hospital. Instead, the most common discharge "plan" was "self without an outpatient referral or service linkage."[62] The 38%-without-a-referral figure became a battle-cry for opponents of expanding conservatorship and was a touch point in multiple grillings at Supervisor hearings:

> *Supervisor 1*: I heard that 38% of people are leaving without a referral. What will it take for them to get the handholding they need from PES to not just keep cycling through the system, to get off this hamster wheel?
>
> *Auditor*: Some of these patients may not need a residential treatment, they're stable enough to go home, they can just see a psychiatrist at a later point. Some might have private insurance, which is not something the Department of Public Health can address.
>
> *Supervisor 2*: Do you have any idea of how many of them wind up back at PES?
>
> *Auditor*: We don't know if they wind up in outpatient. Tracking that would be great.
>
> *Department of Public Health (DPH)*: We're actually hitting our target, which is that 65% of PES discharges are not readmitted in sixty days.
>
> *Supervisor 2*: That sounds like 35% are readmitted in 60 days…
>
> *DPH*: We have to respect patients' choices. They may choose to decline our referral to outpatient services.
>
> *Supervisor 3*: When I look at these numbers, it seems like we're finding ways to say people are stabilized and just send them on their way, because we don't have the ability to send them to any other level of care, because of capacity issues. There's no waitlist because we don't even bother.
>
> *DPH*: We agree bed capacity could be increased. Most people would accept a referral… if it was a place to stay (Fieldnotes, 5/1/19).

This last point was crucial, given that 70% of PES visits were by individuals who were currently homeless.[63] An inpatient psychiatrist at The General admitted, "It's just such a mess. You discharge them with a list of shelters, but they already know where the shelters are. They don't like living in shelters, they don't feel safe in shelters, they'd rather go live on the streets" (Interview, 9/10/18).

The answer to questions about whether and why homeless users of PES were choosing to refuse what little there was on offer clearly depended on assessments of the real origins of their problems. According to 2016 data, 47% of people PES "were not necessarily mentally ill—they were high on meth."[64] In the first part of this paper visiting, I presented data that suggested most people with substance abuse were quickly discharged from ERs. Clearly, meth and mental illness have different moral valences that partly drove clinical decision-making. A doctor who provided "street medicine" for homeless individuals argued:

> The narrative is 'we have all these people with mental illness.' The reality is, of what people are responding to, is, 'we have all these people who are methamphetamine users are acting bizarrely and behaviorally highly dysregulated,' and they might or might not have permanent psychiatric and neurological damage from methamphetamine use and might or might not have a diagnosis of a severe mental illness before they started to use, but now they're using

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[62] San Francisco BLA, *Performance Audit*: v. 56% of admissions were involuntarily, which actually seemed relatively low for a public psychiatric hospital in California.

[63] San Francisco BLA, *Performance Audit*: vi.

[64] Dembosky, April. May 8, 2019. "Meth Vs. Opioids: America Has Two Drug Epidemics, But Focuses On One." *California Healthline*. Retrieved May 9, 2019 (https://californiahealthline.org/news/meth-vs-opioids-america-has-two-drug-epidemics-but-focuses-on-one/).

> methamphetamine, and unless you have a team that doesn't more or less say, 'I can't help this person until they stop using drugs'…it's really hard to work with methamphetamine users. What could be more compelling than a blast of meth? (Interview, 2/14/19).

The county conservator insisted, "It's not that we're refusing referrals for these people, it's just that the meth clears out of their system in a few hours, so the hospital can't even make an application" (Interview, 7/7/17).

Even if they did, placements would be a challenge. For all the ubiquitous narratives of that many people with mental illness are "dual diagnosis," San Francisco still had a bifurcated system that largely separates mental and substance use treatment. The largest provider of residential drug treatment services in the city admitted: "We do turn people away…[We cannot take] people who are actively psychotic or can't manage their activities of daily living." But, she noted, "There is no higher level of care for them." Of those that did make it in, "94% of the people who come into our services sleep outside before they come in," and, shockingly, "45% transition back into homelessness after they leave" (Interview, 2/27/19).[65] DPH did not have direct control of supported housing for its clients; a separate Department of Homelessness, with its own criteria, did. As members of the ARF working group pointed out, someone transitioning from Board and Care to Supported Housing did not help the latter department achieve its key metric of housing people off the street (Fieldnotes, 4/18/19).

One evident source of frustration among county supervisors was that, by all accounts, San Francisco's public mental health system was relatively well-funded, with a $400 million behavioral health budget nearly twice as much per capita as that of Los Angeles.[66] One city official told me:

> We're a mix of Sweden and Tijuana. Where we're located [in the Tenderloin], you can find a social worker anywhere you go. We are dripping with social services. You have people with seven social workers, and they're still unhoused. It's not a matter of adding another social worker when someone is camped out one block from a behavioral health clinic (Interview, 7/7/17).

Indeed, by 2018 the discourse had largely moved away from adding new services to, as described in the next section, finding ways to force recalcitrant persons to accept them.

SB 1045: Conserving Those 'Dying on the Streets'

Conservatorship is a little discussed provision of the LPS act which has not been the object of any academic study since the early 1990s and whose exercise is barely regulated or even tracked by the state; the little data available shows only its declining use. I could not ascertain how policymakers identified it as a response to the cycling of homeless people between social, mental health, and drug-treatment services—and between services and nothing at all. As one county supervisor observed at a hearing:

> I've visited everywhere in the system: the behavioral health court, the locked wards, the outpatient clinics, PES. I asked everyone, 'what is wrong with our system?' and not a single person said, 'we need to reform our conservatorship laws.' They said, 'we don't have enough treatment beds in the system, we don't have places to send people' (Fieldnotes, 5/13/19).

Nonetheless, when San Francisco State Senator Scott Wiener announced his bill, SB 1045, to expand the use of conservatorship in 2018 to encompass "chronically homeless people with severe mental illness or drug addiction," he presented it as an inescapably necessary measure:

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[65] This seems like a substantial change from Gowan's (2010:212) research in the late '90s in San Francisco, when surviving the strictures of rehab was still a reliable route into housing.

[66] Los Angeles spends $236 per person per year versus $452 in San Francisco.

> California is in the midst of a crisis, with very sick people suffering and dying on our streets. This is a life-or-death situation, and it is beyond inhumane to sit back and watch as these people die. We must take action, and action means helping people get off the streets, into housing, and into supportive services to get their lives back. The current conservatorship law is inadequate…Our counties need more tools to help those who can no longer help themselves and to get these individuals housed and into life-saving services.[67]

Wiener was not wrong: in San Francisco, 400 homeless individuals die on the street per year, 35% of them subsequent to an overdose and 47% with meth in their system (Fieldnotes, 5/13/19).[68] Whether conservatorship made sense as a response, though, rested on competing understandings of the social, medical or moral origins of homelessness and evaluations of the state of the mental health services that homeless individuals seemed to be rejecting.

One of the more bizarre tropes in media coverage of SB 1045 was the relabeling of the LPS Act as a bill that, as the Chronicle put it, essentially eliminated involuntary treatment and thus "Lets mentally ill choose to stay on streets."[69] In an interview with Wiener on local television, an announcer said the bill was "a new type of law that is basically bringing back an old one, called conservatorship"[70] that would create a way to take "people on the streets, totally passed out…[and] put them in a hospital." Wiener declined to correct him or specify that the law provided ways to "put [people] in a hospital." By insisting that "governments' hands are tied when gravely disabled Californian's experiencing homelessness refuse services," the implication, as soon-to-be Mayor London Breed put it in 2018, was that "without changes to state law, our ability to…impact [the mental health crisis] is incredibly limited."[71]

SB 1045 was actually among a flurry of bills that sought to broaden the use of conservatorship. The fact that it was the only one that made it to the governor's desk is revealing. Two other bills sought to expand the definition of "Grave Disability" to include individuals who lacked the *capacity* to make informed decisions about food, clothing, or shelter, or who refused necessary medical care. The California Hospital Association helped scuttle both by claiming (probably correctly) that they would increase the number of individuals brought in on involuntary holds without changing hospitals' capacity to treat them.[72] SB 1045 was appealing, in part, because it sought not to add new individuals to the system but to use conservatorship to stabilize individuals already in it who had "frequent detention for evaluation and treatment" "high-frequency emergency department use" or "high-frequency jail detention."[73] As San Francisco's plan for implementing SB 1045 noted, "the individuals who have been identified as potentially eligible…are not a new

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[67] Wiener, Scott. February 1, 2018. "Senators Wiener and Stern Announce Bill to Expand Conservatorships to Help Mentally Ill and Drug-Addicted People Dying on California's Streets." Retrieved May 10, 2019 (https://sd11.senate.ca.gov).

[68] An investigation in 2019 showed that deaths among the homeless in L.A. had jumped 76% in the last five years, much faster than the overall growth in the homeless population. Gorman, Anna and Harriet Blair Rowan. April 23, 2019. "The Homeless Are Dying In Record Numbers On The Streets Of L.A." *California Healthline.* Retrieved April 26, 2019 (https://californiahealthline.org/multimedia/the-homeless-are-dying-in-record-numbers-on-the-streets-of-l-a/).

[69] Knight, Heather. December 12, 2017. "SF Looks to Change Law That Lets Mentally Ill Choose to Stay on Streets." *The San Francisco Chronicle.* Retrieved May 10, 2019 (https://www.sfchronicle.com/news/article/SF-looks-to-change-law-that-lets-mentally-ill-12422969.php).

[70] Matier, Phil. March 10, 2019. "At Issue: Housing Crisis / Homeless 'Conservatorship.'" *KPIX 5.* Retrieved March 12, 2019 (https://sanfrancisco.cbslocal.com/video/4043993-at-issue-housing-crisis-homeless-conservatorship/) .

[71] Wiener, "Senators Wiener and Stern Announce Bill."

[72] Wiener, "Why Is It So Hard."

[73] Senate Judiciary Committee. 2018. *Conservatorship: Chronic Homelessness: Mental Illness and Substance Use Disorders.* Sacramento, CA: California State Legislature.

population of individuals in need of services…They already receive crisis-level interventions several times a year…[and] cycle in and out regularly."[74] This suggested that the bill would pay for itself, which was good because it contained no new funding for mental health services or conservators.

Ultimately, the bill removed references to "chronic homelessness" and narrowed its target to individuals "incapable of caring for the[ir] own health and well-being due to a serious mental illness and substance use disorder, as evidenced by eight or more 72-hour involuntary holds" in the last year.[75] Continuing a pattern I noted in Chapter 1, then, SB 1045 envisioned a mental health system that would target new, enhanced services towards high users of the "wrong," expensive services. Reference to a group of super-high utilizers were ubiquitous in discussions of the bill. One supervisor reported that "In four months, nine people visited PES 168 times…They're taking a tremendous amount of resources, and not going anywhere" (Fieldnotes, 5/1/19).[76] Even if "mental illness" would remain one piece of the qualification for SB 1045 conservatorships, it wasn't the centerpiece. The Director of SF's Department of Public Health declared her support for a bill that would "provide our community members who have addiction disorders and who are homeless with more intensive treatment options."[77] Observed a social worker at a psychiatric hospital, "SB 1045 is not he 'housing conservatorships' bill"—as supporters called it—"it's the 'meth conservatorships' bill."[78] At least conceptually, the legislation built on the growing consensus in psychiatric research that, as brain diseases, addictions could be treated medically and involuntarily, independently of the moral fortitude of the addict (Williams et al. 2014).[79]

Over the course of 2018, the bill passed through a series of committees with only one dissenting vote and made it through the State Assembly and Senate unanimously. Groups like the ACLU and Disability Rights California successfully added new hurdles for the bill's implementation, however. The final version would create a five-year pilot program in San Francisco, Los Angeles, and San Diego counties only if the counties opted in. To do so, they would have to issue a report certifying that they had sufficient voluntary services to meet the targeted individuals' needs and that these new conservatorships would not detract resources from providing that same level of care to others who wanted it. San Diego and Los Angeles immediately passed on implementation—probably, I was told, because there was no way they could claim their system was adequate enough to meet these requirements. In meetings over the implementation of the bill in San Francisco, however, the city relentlessly reiterated that the 55 individuals who met the 8-5150 threshold[80] had been offered ample services and refused them:

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[74] Department of Public Health. "Report on the Implementation of SB 1045." *Unpublished*. San Francisco, CA.

[75] Senate Judiciary Committee. 2019. *Conservatorship: Serious Mental Illness and Substance Use Disorders*. Sacramento, CA: California State Legislature.

[76] Trivedi et al. report that the 9% of persons subjected to an involuntary hold more than five times in a five year period accounted for 39% of all involuntary holds and 9% of *all* ambulance encounters in Alameda County. The SF Fire Department similarly claimed that 2.5% of "frequent 911 users" were using "19% of total resources" of the department for transporting persons (Fieldnotes, 2/28/19).

[77] Wiener, "Senators Wiener and Stern Announce Bill."

[78] Qtd. in Sawyer, Nuala. 2019. "Mental Health, Homelessness and Civil Rights: S.F.'s Crisis of Conscience." *SF Weekly*. Retrieved April 2, 2019 (http://www.sfweekly.com/news/mental-health-homelessness-and-civil-rights-s-f-s-crisis-of-conscience/).

[79] This finding can be read in dialog with Netherland and Hansen's (2017) association of the medicalization of addiction (particularly, to opioids) with a less criminal-justice centered response to it. While avoiding incarceration was certainly a stated goal of SB 1045, here medicalization actually served as justification for involuntary inpatient treatment, which one county supervisor pointed out actually sounded a lot like incarceration (Fieldnotes, 5/13/19).

[80] According to the county, these 55 individuals averaged 16.5 visits per year and had been homeless for a mean of 8.9 years (Fieldnotes, 5/13/19).

> I want to emphasize that for the people potentially affected by this, this is not a new group. It's people that we know and we're trying to offer them coordinated and better services. Voluntary services are always going to come first, but what if they aren't engaging with us? We need conservatorships to have more time to hear what they're saying and work with them (Fieldnotes, 12/7/18).

In response to critiques, Wiener insisted, as well, "Clearly, we need to invest a lot more in mental health and addiction services…But to walk in and suggest that you can't get those voluntary services in San Francisco, it's inaccurate in the extreme" (Fieldnotes, 4/18/19).

Predictably, the mobilization against the implementation of SB 1045 in San Francisco emphasized civil rights concerns (see Figure 3.8). Because most 5150 holds in California are initiated by police, opponents pointed out, this meant that non-clinical evaluations would be the key determinant of whether someone qualified for expanded conservatorships.[81] An advocate for the Coalition on Homelessness noted at one community forum, "A police officer can 5150 you eight times, even though the psychiatrist says you don't meet the standard and doesn't admit you." A speaker from the ACLU declared that conservatorship was "the greatest deprivation of civil liberties aside from the death penalty." In this rendering, "homeless people are being used as political scapegoats for political gain" (Fieldnotes, 11/30/18). As one newspaper report observed, the three biggest proponents of the bill at the state and city level had long-established reputations for supporting hard-nosed responses to homelessness, like tent sweeps and aggressive quality-of-life citations.[82]

For both sides, SB 1045 built on a complex rhetoric around "choice,". Anti-SB 1045 forces similarly thought that even severely mentally ill individuals could rationally turn down what was offered to them. They instead claimed that, in refusing particular propositions of help, individuals were "not refusing housing in general, but refusing a particular offer of housing. People could have a good reason to refuse a shelter or an SRO" (Interview, 12/19/18) if they saw it as low quality. Media coverage of SB 1045, however, emphasized how cases like that of an elderly woman in the Mission neighborhood who the author claimed had rejected 60 offers of supported housing showed the need to override choices that were, at least at times, presented as willful.[83] Narratives of "hamster wheels" and "merry-go-rounds" favored by county supervisors were emblematic of a discourse of frustration with autonomy rather than a desire to use treatment to restore it. At one state hearing, Wiener recounted the story of a 38-year-old woman with BiPolar Disorder and meth use:

> She's violent towards passers-by, she went to PES twice las month, and the judge let her go because she was not 'gravely disabled' because she could say where she would get food and clothing. Four days later, she was out and undressed in public. These are people we have known for years. They have not accepted voluntary services and have not stabilized (Fieldnotes, 4/18/19).

While discussions of the bill at times elided the degree to which it was about coercion—and not "getting people into housing" or "preventing people from dying on the streets"—there were moments where the broader political pressures behind it emerged. At one hearing, a supervisor commented, "I'm going to neighborhood meetings and people are so frustrated [with homeless people]…I'm worried someone is going to get hurt." A spokesman for the Public Works

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[81] For an analysis of the uses of 5150s for administrative rather than medical reasons, see Seim (2017).

[82] Sawyer, "Mental Health, Homelessness and Civil Rights."

[83] Knight, "SF Looks to Change Law."

Figure 3.8: Flyer Opposing SB 1045 Implementation in California

Source: The Coalition on Homelessness.

Department concurred, "There's a risk neighbors get so frustrated they go vigilante and light a tent on fire" (Fieldnotes, 2/28/19). At a carefully choreographed meeting on SB 1045 implementation that emphasized the ultimate goal of helping those individuals targeted for conservatorships to "recover" and live "productive lives," the chair from the Mayor's Office asked for final comments. A woman representing a neighborhood association stood up. "I get what everyone is saying about voluntary services and trauma but… we've had it up to here," she declared, motioning above her head. "You walk down the street and you're worried someone will hit you on the head. This is no way to live in a city. There are homeless people who just should not be there" (Fieldnotes, 12/7/18).

This community pressure to expand conservatorship was not going away, and clearly not limited to San Francisco. One county behavioral health director from a small county noted, "99% of the time, there's community pressure to be putting someone on county behavioral health to think about a conservatorship, whether it's families, local merchants, or the sheriff's office" (Interview, 3/26/19). A public defender concurred, "I've done this caseload for 10 years, and recently they're picking up more and more homeless people, applying for conservatorship, and it's about getting people off the streets" (Interview, 4/25/18). San Francisco ultimately approved the legislation in June 2019, but the debates around it suggested an upswell of submerged support for an expanded continuum of constraint that was unlikely to stop there, as I discuss in the last (and final) section.

California's New Continuum of Constraint

What kind of coercion was SB 1045 actually intended to exercise? Traditional civil commitment is binary: someone is dangerous and is placed in a hospital involuntarily, or they are not dangerous / gravely disabled and are offered voluntary services in the community. Scholars have argued this is giving way to a more complex range of coercive techniques intended to manage not just moments of overt dangerousness but predicted risk over time (Brodwin 2012; Gong 2017; Rose 1998). This chapter has already shown that the picture has always been more complicated: conservatorship already allowed individuals who were not dangerous but gravely disabled to be placed in institutions, ranging from hyper-secure state hospitals to unlocked Board and Care homes, for long periods of time.

Nonetheless, SB 1045 represented a new attempt to more carefully calibrate the level of constraint exercised based on an individualized assessment of a person's need for it. Proponents of the bill began referring to it as "Housing Conservatorships" to emphasize that the new program "requires the provision of Permanent Supportive Housing (PSH) in order to pursue conservatorship," a "necessary yet novel component" that differentiated it from traditional conservatorships.[84] The bill was thus consistent with a broad trend to treat PSH, in which someone is given a lease, pays subsidized rent, and lives in an "ordinary" building with treatment and social supports on the outside, as the ideal landing place for public mental health clients (Myers 2010). In truth, absolutely nothing in the bill required that these individuals go into PSH, as opposed to a locked facility.[85] But planning documents constantly re-iterated that new conservatees would be constantly reassessed and stepped out of the program when possible, ensuring a "right to a fresh start and hope for a healthier future," as the interim mayor put it in one editorial.[86]

So designed, Housing Conservatorships would be one more step in a continuum of care and constraint that was supposed to help people flow to lower levels of each. Indeed, between the hard constraint of involuntary hospitalization and the full freedom of life in community, some counties in California had already plunked two intermediate steps. After the killing of Laura Wilcox, a college student working in a mental health clinic, California passed "Laura's Law," modeled after New York's Assisted Outpatient Treatment (AoT) program. The law provided for court-mandated outpatient treatment for individuals who were "likely to substantially deteriorate" and were "unlikely to survive safely" without treatment, with which they had a "history of non-compliance."[87] Nineteen of fifty-eight counties had implemented the program at the time of writing, among them San Francisco.[88]

One of the protections opponents succeeded in adding to SB 1045 was that individuals would have to have been found inappropriate for or failed out of AoT prior to going on a housing conservatorship. Failing wouldn't be hard. Unlike New York's AoT statute, California's came with no additional funding or provision for enforcement making it, arguably, a "sham" (Geller 2006:241). Coercion on the cheap, though, was the point. For the head of one county's AoT program, the program used the "symbolic weight of the court to leverage someone into care" through a much contested "black-robe effect" (Interview, 9/1/17).[89] In any case, being on AoT jumped individuals to the front of the line for housing and intensive services. Some public defenders we spoke with actually supported using AoT court orders as a "contract" between patients and providers who

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[84] Department of Public Health. "Report on the Implementation of SB 1045." *Unpublished.* San Francisco, CA.

[85] Claiming as such, though, may have been necessary for the city to claim it had sufficient resources to meet conservatees' needs; while they obviously could not claim that they had sufficient locked places, the city was able to insist that it had the "largest per-capita supportive housing portfolio of any major city." Senate Judiciary Committee, *Conservatorship: Chronic Homelessness.*

[86] Ferrel, Mark. March 11, 2018. "Helping Those Who Cannot Help Themselves." *The San Francisco Examiner.* Retrieved March 12, 2018 (http://www.sfexaminer.com/helping-cannot-help/).

[87] California Welfare and Institutions Code. *ARTICLE 9. The Assisted Outpatient Treatment Demonstration Project Act of 2002 [5345 - 5349.5].* Retrieved May 7, 2019. (https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=1.&chapter=2.&article=9.).

[88] Treatment Advocacy Center. February 2019. *A Promising Start: Results from a California Survey Assessing the Use of Laura's Law.* Arlington, VA.

[89] Whether the efficacy of AoT stems from additional services or coercion is contested (Kisely and Campbell 2014; Schneeberger et al. 2017). California's AoT program contains neither, really.

might not otherwise take them (Interview, 4/25/18).[90] But, as another admitted, "The savvy ones realize that they can just say, 'okay, thank you, no thank you' to AoT and there's not a lot of power." He added, "Those clients wind up getting conserved" (Interview, 4/17/19).

Yet even the meaning of "conservatorship" itself was becoming more gradated. In San Francisco and Alameda counties, new "Community Conservatorship" programs created a new intermediate space for clients who are "gravely disabled, but not homicidal, not suicidal, not too dangerous…" (Interview, 7/7/17). Under these programs, which are "100% voluntary," clients had to "agree to give up their right to refuse medication." In return, "we will work with you to identify housing and will provide you that full level of care. There's no coercion, it's just new benefits to you" (Interview, 3/23/18). Community Conservatorship clearly had more heft than AoT, because the threat of a full conservatorship lurking behind it. But, similarly, it wagered that at least some individuals previously subjected to heavy, full-time oversight in a locked facility could live in the community—meaning, in most cases, a single-room occupancy motel or low-quality subsidized rental unit—with some cajoling from the judge to be medication compliant. Community conservatorship would lessen the restrictions on the person's rights and, in return, loosen the county's responsibility to provide for them. It paralleled discussions among legal scholars about finding a new balance between "liberty and care" (Simon and Rosenbaum 2015:41; see, also, Bennion 2013), but added another dimension: cost.

The irony was that these new forms of constraint at least rhetorically had to claim to be moving away from the things that most people wanted them to do, which was to stabilize and control people with severe mental illnesses over the long term. A similar point could be made for parallel discussions over preserving the place of Board and Cares in the "continuum of care." At the California Behavioral Health Planning Council, a facilitator of the ARF working group noted that "In order to get any grant money from SAMHSA [the federal government], we are going to have to say that our goal is to move people to a lower level of care with a higher level of functioning." Someone suggested this might mean creating a "Super Board and Care"—a new level focused on moving people from an IMD down—while another proposed a "Board and Care Light" as a waystation to PSH. One working group member who was head of a housing agency agreed:

> Yes, we need to be clear that an effective model [for a Board and Care] is one that that transitions people down. We need to get people out of ARFs so those services are available to people who need them. We surveyed 300 of our residents, and only 5% saw their ARF as permanent…

Another participant, from a family advocacy organization, cut her off: "For some people, they are permanent, that's just it" (Fieldnotes, 4/18/19).

In truth, across a range of organizations, interviewees were starting to question the universal admonitions to think of every service as "transitional" (see Chapter 1). While over half of my U.S. interviewees identified "housing" as the key challenge facing the mental health system—no other concern came even close to this level of consensus—they were more likely to say that meant Board and Care, nursing facilities, or locked wards than independent units (Figure 3.9). The operator of a "super" Board and Care with intensive, recovery-oriented services told me:

> 70% of our clients could move to a lower level of care. But 30% need this level of care for the rest of their lives. When do you get to retire from your mental illness? My grandmother, moves into a Sunshine Villa, they move to retirement communities, because they have caregivers there. So why is there this huge push for lower level care, step down? (Interview, 2/27/18).

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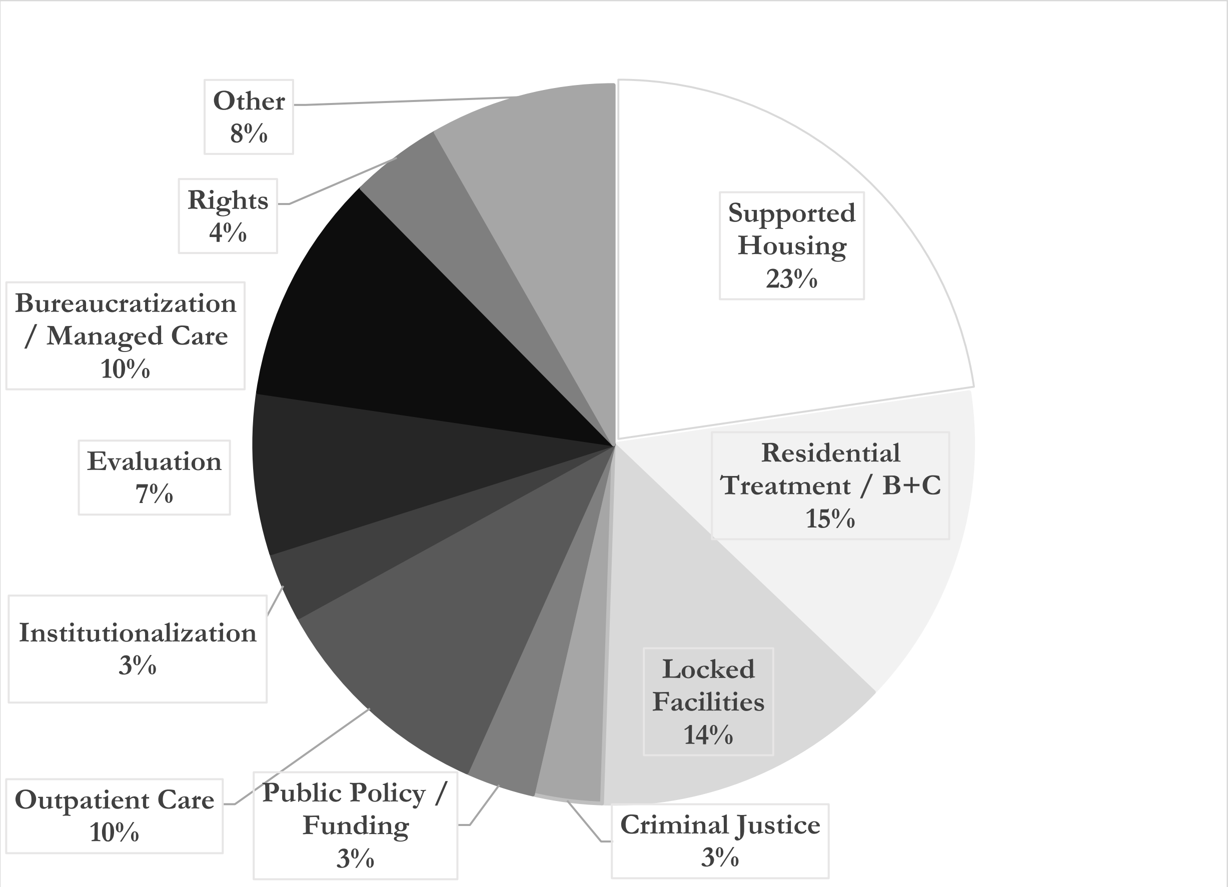
[90] I discuss how legal tools like this were leverage to get undesirable clients into services in more detail in Chapter 4.

Figure 3.9: Central Challenge in Mental Health Care (U.S.)



Source: Interviews with 97 U.S. policymakers and

Many were turning, in particular, against the idea that every person with a severe mental illness could make it in PSH with an occasional dash of coercion added through AoT, Community, or "Housing" Conservatorship. Although such housing was, at least in San Francisco, usually no more than a heavily subsidized, tiny studio in a building with an on-site social worker, it was the closest thing to full community integration most people could seriously envision. But the policy director for a city homelessness agency confided:

> There's kind of a dirty secret. There's this assumption that everyone in shelter is able to live independently in housing. So if the housing stock is there, all of those people can leave tomorrow. That's just not true. That's not fundamentally true. Looking at our client population, there are folks that will never be able to live independently because they are so severely mentally ill. They're not able to function on their own and we have no recourse, we have nowhere to put these folks (Interview, 12/14/16).

In fact, the Budget and Legislative Analyst's office in San Francisco found that, five years after being placed in "permanent" housing, only 47% remained.[91] The clinical team I observed was constantly putting out fires (sometimes, literally) that their clients had started in their placements; eviction was a real and constant risk (Fieldnotes, 11/30/18, 12/18/18). Just being housed, moreover, didn't stop someone from causing the kinds of disruptions to which community members and policymakers

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[91] Budget and Legislative Analyst's Office. 2016. *Impact of Supportive Housing on the Costs of Homelessness*. San Francisco, CA.

were turning to the behavioral health system to contain: "We get calls about people on the street shouting at passers-by. We know who they are. They're housed. They're receiving treatment. We can't just lock them inside" (Interview, 12/18/18).

Perhaps because of these experiences, a surprising number of outpatient providers—otherwise fervent believes in community-based, recovery-oriented services—nonetheless believed "we need to do a little more forced care" (Interview, 4/27/18). They weren't always envisioning just AoT or a community conservatorship or even a short-term civil commitment, but also long-term placement in a structured (usually meaning, locked) facility. Most county conservators we spoke with understood that this was probably the appropriate level of care for those targeted by SB 1045, and that the preferences of private providers needed to be overridden to get their clients there:

> My opinion is that this reform is completely one-sided. They need to say, 'Okay, we're going to build this facility, this is how many beds it's going to have, and only people on conservatorship are going to be allowed into this facility.' And if the operator says, 'well, we only want this kind of person, we're only going to get this kind of license…' you tell them they have to take them, that's it (Interview, 4/24/19).

It was precisely because this scenario sounded implausible that public defenders, housing providers, inpatient clinicians, and county conservators usually thought the reform was unlikely to work. One public defender told me:

> We're getting to the heart of the issue with the new proposed law. It's not that they can't already conserve the people who they are trying to target. They can already catch those people…The problem is that we don't have that dual diagnosis bed to send them to after they stabilize…That's the main problem I see with trying to expand the ability to take away peoples' rights. They have that ability and it's not judges denying that. It's the system deciding that we can't help these people, so we're not going to bring them it because they'll just languish in placements they don't need to be in. We don't have the right level of care for them (Interview, 4/17/19).

Their opposition, itself, revealed how much the theoretical terrain over how to reorganize mental health services had shifted. Some argued that the right mix of voluntary services could work for just about anyone; others, however, were doubtful. Few interviewees claim that conservatorship was, itself, an unconscionable infringement on the civil liberties of homeless people. Rather, they simply did not see this system of public constraint and private provision as able to meet its obligations to people whose rights it did take away.

Conclusion: Bring Back the Asylum?

It is now widely acknowledged that de-institutionalization failed in part because it didn't happen. Throughout the 1970s and '80s, severely mentally ill were trans-institutionalized into prisons and jails, nursing and Board and Care homes, and into the "institutional circuit" of the "homeless archipelago" (Gowan 2010; Hopper et al. 1997). But contemporary California might have finally arrived at a moment of true de-institutionalization, in which these human warehouses are releasing internees in tandem. The expansion of "community / housing" conservatorships and involuntary outpatient treatment, combined with new rehabilitation- and transition-focused structured living arrangements, could transfer more mentally ill in the expanding portfolio of supported housing being created in the state's broader efforts against homelessness. A fluid continuum of descending care, control, and costs would move the chronically ill to live independently and invisibly in the community.

Next to the scale of de-institutionalization, the opening of 40 new beds for conservatees in a San Francisco IMD in 2018 seems small.[92] The Mayor promised shortly thereafter, though, that "we're going to open another 100 beds next year" (Fieldnotes, 3/18/19). At a hearing earlier that week, a supervisor pleaded with the Department of Public Health, "How many [psych beds] do you need? 200? 400?" (Fieldnotes, 3/14/19). To my surprise, we were able to identify ten other counties in the state with approved or in-process plans to open new locked psychiatric beds.[93] A consultant who worked with the California Hospital Association told me, "There's just such a crisis now that you can finally get managed care plans and the government to pay enough to make it work" (Interview, 3/6/18) for the private, for-profit entities behind them.

At least some advocates saw the same trends we did. As a woman testified to the Planning Council, "My deep, deep fear is that there are politicians who want to go back to state hospitals, only privately run" (Fieldnotes, 4/18/19). She was not being paranoid. Governor Newsom's mental health platform stated, alongside more predictable calls for early intervention and police crisis-intervention training, that:

> We will also expand the options available for inpatient care…Rather than lead the nation in this critical aspect of care, we fall well below the national average. My administration will direct both funding and political capital into the effort to revitalize the acute-care system at the community level, pushing through the zoning issues and discrimination that often serve as obstacles to building specialized facilities.[94]

Some of the momentum could be coming from even higher up. It was remarkable that Hillary Clinton released a mental health plan at all, but her proposals were a boiler-plate rehash of the principles of community care elaborated by Kennedy in 1963.[95] More strikingly, the first Democrat to do so in 2019, Amy Klobuchar, called for repealing the "IMD-Exclusion" which barred Medicaid funds from going to inpatient psychiatric care.[96] Under an existing waiver program, twenty-six states already have approval to use federal funds to finance inpatient psychiatric and substance abuse care (a shift impelled by the opioid epidemic, but with wider-reaching implications).[97]

Psychiatrists have been warning of a return to the state hospitals at least since the 1980s, when they predicted that the rise of Medicaid managed care would push unprofitable patients directly back onto the states (Sharfstein, Frank, and Kessler 1984). They underestimated the unwillingness of public actors to directly provision services and to simply leave the severely disordered with nothing at all. Now, though, calls to "Bring Back the Asylum" have support within the psychiatric profession based on the conclusion that "even well-designed community-based programs are often inadequate for a segment of patients" (Sisti, Segal, and Emanuel 2015:244). Re-institutionalization has a new, humanitarian face. In his statements on SB 1045, Senator Wiener relentlessly emphasized, "It's not progressive to watch people die on our streets."[98] Once we accept, as he frequently reminded interviewers, that "we do have a very large conservatorship program in

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[92] An additional 14 beds would be available for other counties to bid on, of course. Bay City News Service. 2018. "City Adds Dozens of Conservatorship Beds To Help Mentally Ill." *SFGate*. Retrieved March 10, 2018 (https://www.sfgate.com/news/bayarea/article/City-Adds-Dozens-Of-Conservatorship-Beds-To-Help-12731188.php).

[93] Kimberly Nielsen and Didi Wu were particularly helpful for tracking this.

[94] Newsom, Gavin. January 19, 2018. "Getting Serious About Mental Health." *Medium*. Retrieved February 22, 2019 (https://medium.com/@GavinNewsom/getting-serious-about-mental-health-8c09ad95a5ae).

[95] The Office of Hillary Rodham Clinton. "Mental Health." Retrieved May 10, 2019 (https://www.hillaryclinton.com/issues/mental-health/).

[96] Schneider, Elena and Brianna Ehley. May 3, 2019. "Cheat Sheet: How Sen. Amy Klobuchar Would Address Drug Addiction." *Politico*. Retrieved May 5, 2019 (https://politi.co/2IWFBe5).

[97] Kaiser Family Foundation, *MediCaid Moving Ahead in Uncertain Times*.

[98] Wiener, "Senators Wiener and Stern Announce Bill."

California—it's called jail,"[99] simply trans-institutionalizing people back into mental health facilities seems much more palatable.

If this chapter has identified barriers to this movement, it is not rooted in a consensus about patients' rights or a firm faith in the power of voluntary services, both of which have clearly weakened. Instead, an expansion of constraint in the U.S. must reckon with the contradictions of a "delegated welfare state" (Morgan and Campbell 2011) in which private institutions are expected to fulfill public functions (Medicaid managed care being a notable example). Private mental health facilities are largely not obligated to take people, in the way that private prisons or immigration detention facilities that are part of the coercive "right hand" of the state might be. But unlike other parts of the caring, "left hand" of the state, people don't come to these facilities on their own. As such, a system that legally mandates difficult people to live in private institutions while respecting those institutions' market prerogative to choose who they serve will generally lead to the most difficult people being bounced between them. In such a situation, the most reliable private institution to which the state can delegate welfare functions winds up being families, often the very actors turning to the state for help.

In the end, "the trade of lunacy," noted William Belcher in his 1796 critique of private madhouses in England, "Is an approved receipt [sic] to make a lunatic" (qtd. in Porter 1989:169)—out of both patients and policymakers. State hospitals got around the reluctance of "privatized inpatient psychiatry…[to fulfill] the social control function of the mental health system" (Yoon 2011:448) vis-a-vis people with "co-occuring" mental and physical health issues, drug use, and problematic behaviors by being run by the state. It is a striking if unsurprising comparative insight that the idea that some mental health services will have to be public to serve the most troublesome persons is blindingly obvious in France and barely contemplated in the U.S. As pointed out in Chapter 2, attempts to increase the role of private associations in France through the introduction of psychic handicap had to deal with similar challenges to those documented here processes of sifting out the most difficult cases. Moreover, in France judges *cannot* order someone to live in such disability-serving institutions. But with its universalistic health system and stronger support for families (characteristic of continental welfare states – see Esping-Anderson (1990)) there was a more effective safety net nonetheless, not just a handful of islands of support to hop between.

In 1961, Erving Goffman (1961:384) speculated that "if all the mental hospitals…were emptied and closed down today, tomorrow relatives, police, and judges would raise a clamor for new ones." Goffman undersold the impact of his and others' critiques of institutional psychiatry and the bad taste (both fiscal and ethical) state hospitals would leave in the public's mouth. For those in the cynical vein of Foucault (1977:228), who declared the "prisons resemble factories, schools, barracks, hospitals, which all resemble prisons," the result has been a "continuity of confinement" (Harcourt 2005:1766) that went from hospitals to the criminal justice system or Board and Cares. But the current clamor for "mental hospitals" *specifically* may well provide Goffman to be right. In the end, perhaps, "relatives, police, and judges" are looking at the shuffling of the mentally ill between institutions and realizing that prisons are *not* hospitals which are *not* nursing homes which are *not* homeless shelters. Even if we believe that all of these institutions should be high-quality, dignified, and humanizing, our inexorable human tendency to use classification to make sense of the world (Douglas 1966; Durkheim 1965; Fourcade 2016) makes it seem important to sort people properly between them—which is why dealing with individuals who are "all of the above" presents such a perplexing challenge.

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[99] Wiener, "Why Is It So Hard."

Chapter 4: Courting Compliance and Consent: The Judicial Management of Madness in Paris and New York City

In a drab courtroom inside a public psychiatric hospital in Paris, a judge and a court clerk speed through twelve hearings for patients who have been involuntarily hospitalized. Medical certificates hastily written by psychiatrists explain why the patients must continue to receive medical care, emphasizing their ongoing symptoms and "ambivalence" towards treatment. As each person shuffles in—accompanied by a lawyer they have met a few minutes prior—the judge asks them, "You've been hospitalized without your consent, and the law requires that a judge rule after twelve days on whether you stay. Are you okay with remaining until you feel better?" Sometimes it takes less than a minute for him to get a patient to nod their assent. An ocean away in New York, many patients look similar—frequently non-white, poor, and overwhelmingly suffering from psychoses like schizophrenia—but the hearings have a different tone. Defense lawyers challenge psychiatrists' diagnoses and their interpretation of problematic behavior as "dangerous," the key criterion for civil commitment. If there were any doubts about the priority of medical or legal professionals, the judge settles it: "To all the doctors here, just answer the question that's asked, not the question you wish you were asked. This is a court. You're not in your domain anymore."

These hearings display the competing imperatives facing modern mental health systems: protecting public order, preserving patients' rights, and providing care, in a context where the resources for mental health treatment—notably, hospital beds—are sharply restricted. In both cities, they reveal the ongoing blurring of the legal and health fields, as police and judges play a greater role in pushing people into care (Lara-Millán 2014; McPherson and Sauder 2013; Stuart 2014) and health professionals are tasked with managing precarious and disorderly populations (Bosk 2013; Seim 2017). Moreover, the hearings end similarly: judges rarely release patients. A recent French government report found that judges sided with hospitals 91% of the time.[1] Although no national data is available for the U.S., previous research in other states (for a review, see Appelbaum 1994) and my observations suggest similar results in New York.[2]

Two theoretical frameworks provide an apparent explanation for these outcomes. The literature on professions would point to the enormous cultural authority of doctors as an explanation for their victory in a "jurisdictional struggle" between law and medicine (Abbott 1988; Kellogg 2014; Starr 1982). The hearings might equally appear to be a case of "symbolic compliance," in which professionals collaborate to produce a ceremonial and rote adherence to legal norms that is decoupled from any substantive impact (Edelman 1992; Kelly and Dobbin 1998; Meyer and Rowan 1977).

As the opening paragraph suggests, though, similar outcomes mask very different routes to achieving them. As law and society scholars have argued, legal processes, independently of legal outcomes, are a way through which the state acts upon and attempts to transform people (Carlson 2017; Feeley 1979; Kohler-Hausmann 2013). Legal *process* is a particularly important form of governance in contexts where the state's power to actually enforce final judgments is limited. But what kinds of transformations orient such legal procedures? As I show, the courtroom procedures in New York and Paris are organized around responses to what Eyraud (2013:47) refers to as the

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[1] Robilard, Denys and Denys Jacquat. 2017. *Rapport d'information de la mission d'évaluation de la loi n° 2013-869 du 27 septembre 2013*. Paris, France: Assemblée Nationale: 77.

[2] Out of 100 U.S. hearings I observed dealing with retention of patients, I saw 10 patients released by the court—strikingly similar to the national norm in France.

"embarrassment" posed by the mad.[3] In the U.S., they appear irrational and irresponsible in a legal system founded on rationality and responsibility; in France, they refuse to consent to or to participate in a universalistic medical system where both are the expected precondition for care.

Borrowing from Goffman (1961), I argue that this embarrassment is addressed through the creation of a *serviceable object* in each. I define a serviceable object as a person who is amenable to medical intervention, capable of being granted rights, and minimally responsive to efforts at social control and bureaucratic processing. Conflict and collaboration between professional groups and their invocations of legal norms are underpinned by a shared vision of what a serviceable object is: in the U.S., *compliant calculators* who can rationally assess the costs and benefits of taking medication, and, in France, *suffering citizens* who can recognize their identity as mentally ill and accept the solidarity from the welfare state such an identity entails.

I begin this chapter by considering the literature on professional conflict and symbolic legal compliance and elaborating the notion of serviceable objects, drawing on literatures in comparative cultural sociology and state classification. The next section explains the data for this chapter, which centers on direct observations of 206 hearings in New York and 107 in Paris. I then explore the differences in these hearings along four dimensions. First, I examine the history and policies of involuntary commitment. In each country, professionals and policymakers situate the use of civil commitment within a broader crisis in mental health care systems which manifests as a failure to produce certain kinds of mentally ill persons. Second, I show how the hearings are structured around distinct professional hierarchies: the dominance of doctors and a primacy of care in Paris and the dominance of judges and lawyers and the primacy of rights to due process in New York. Third, I show how the process of hearings achieves symbolic compliance with a right to health in Paris and with criteria for using civil commitment as a form of social control in New York.

In sections two and three, I highlight features of the hearings that are anomalous with respect to the predictions of the literatures on professional conflict and symbolic compliance. For example, judges in Paris go beyond complying with their role as an administrative check on hospitalization procedure to actively encourage patients to consent to care, even though they will rule that consent is legally invalid. In New York, judges demean psychiatrists and lawyers call psychiatric expertise into question but, in the same process, legitimize those psychiatrists' strong-armed efforts to control their own patients. In the fourth section, I explain these anomalies by examining the objects judges, lawyers, and psychiatrists collaboratively seek to produce: suffering citizens or compliant calculators. In the conclusion, I consider how greater attention to the different "serviceable objects" on which professions, law, and the state operate could help explain variation in how states reconcile competing imperatives to protect citizens' rights, economize government services, provide care, and govern disorderly populations.

Literature: Professional Conflict, Symbolic Compliance, and Serviceable Objects

Judicial Review as Professional Conflict

When due-process rights and judicial reviews of involuntary psychiatric commitments were expanded in the 1970s in the United States, commentators assumed it would mark a sharp break with the wholly-perfunctory character of prior external oversight of psychiatric internments (see Appelbaum 1994). As in much institutional theory, the presumption was that "actors affiliated with a professional or organizational group will closely adhere to that group's primary logic" (McPherson and Sauder 2013:181). Psychiatrists' prior prerogative to impose care on their patients would therefore conflict with lawyers' attempts to valorize patients' due process rights.

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[3] This point about the problems posed for the mad in liberal polities is artfully developed by Gong (2017, 2019).

Commentators were offering an analysis consistent with the sociological literature on professions, which presumes that different groups' claims to jurisdiction over some task—like determining who belongs in a mental hospital—are competing and frequently mutually exclusive (Abbott 1988:96; see, also, Dobbin and Kelly 2007; Starr 1982). Indeed, the 19th century consolidation of psychiatry as a new discipline came at the expense of jurists, who had traditionally played a central and independent role in determining whether someone should be placed in an asylum or found criminally irresponsible by reason of insanity (Castel 1988; Goldstein 1987). As with other professional groups, psychiatry's jurisdiction was buttressed by a claim to specialized knowledge (Abbott 1988; Eyal 2013; Timmermans 2005) and a recognition of their authority over the mentally ill by the state (Fourcade 2009; Freidson 1973).

In explaining the different shape of hearings in Paris and New York, however, I find the literature on professions empirically and theoretically limited. The seemingly-dominated position of psychiatrists in New York is out of sync with American doctors' comparatively enormous cultural authority (Starr 1982), including vis-à-vis their French counterparts (Wilsford 1991). The deferential position of Parisian judges runs against the increasingly assertive role of the French judiciary (Adut 2004; Guarnieri and Pederzoli 2002). If France is notable for the latitude it gives to professional judgment (Carson 2007; Porter 1996), when there are multiple professional groups in a given setting it remains to be explained *whose* judgment counts.

This, I argue, depends on the definition and understanding of the object on which that discretion is exercised, i.e. the nature of the patients themselves. From this perspective, the role of the state is not just carving up the world into professional jurisdictions, but shaping the very categories through which professionals understand the nature, purpose, and objects of their work (Bourdieu 2015; Fourcade 2009). The conflict between "law" and "medicine" is constrained by distinctive conceptions of what kind objects are amenable to legal or medical intervention in the first place.

Judicial Review as Symbolic Compliance

In the United States, a wave of research conducted in the 1970s and 1980s concluded that new due process rights and protections for mental patients played a minimal role in de-institutionalization and did little beyond creating new procedural hassles for psychiatrists (see, e.g., Appelbaum 1994; Hiday 1977; Warren 1982). If one interpretation of these findings is that new judicial interventions sparked a professional conflict that doctors quickly won, these studies suggest legal professionals abdicated from the start. Hearings created a new form of "cross-professional collaboration" (Kellogg 2014:914) in which lawyers and judges willingly validated psychiatrists' attributions of incapacitating mental illness while making those attributions seem legitimate in a context of civil rights mobilization.

From this perspective, judicial reviews of involuntary hospitalizations seem like a case of "symbolic compliance," in which institutions ritually enact formal legal protections in place of substantive change (Edelman 1992; Kelly and Dobbin 1998; Meyer and Rowan 1977). So interpreted, the introduction of a novel legal procedure is less about shifting the balance of power between litigants as it is "register[ing] a state of power relations" which "legitimizes victories over the dominated" into "accepted facts" (Bourdieu 1987:817). Over time, such rituals become increasingly detached from their original intent, as powerful organizations come to define what compliance means and judges largely follow suit (Dobbin and Kelly 2007; Edelman et al. 2011).

Indeed, if judges overwhelmingly rule in favor of hospitals (personified in the courtroom by their key witnesses, psychiatrists) against patients, it appears to be for reasons familiar to socio-legal scholars. "Repeat players" like hospitals have a knowledge of legal procedures, positive reputations, and ongoing relationships with judges that patients and their (often-unspecialized) court-appointed lawyers lack (Albiston 1999; Galanter 1974; McDonnell and King 2018). Lawyers might have a legal mandate to investigate and litigate over psychiatric practices but, as Heimer (1999:59) observes, "lawyers and state agents may know the tool [law] well, but one needs to know the material"—the patients and psychiatric treatments themselves—"to be effective." Despite widespread critiques of psychiatry's ability to predict dangerousness, past studies suggest lawyers and judges are simply reticent to question psychiatric evaluations (Decker 1987; Hiday 1977).

As with the literature on professions, though, the analytical power of an approach centered on symbolic compliance has limits. Empirically, I find an engagement of legal professionals in both countries that goes beyond a listless, ceremonial enactment of juridical procedure. More importantly, looking merely at the different formal legal requirements in each country is insufficient to explain the differences between them. Commentators have argued that the attribution of legal rights to mental patients was overwhelmed by a "common sense" understanding that the subjects before the court were above all patients whose "best interest" was psychiatric care (Appelbaum 1994; Holstein 1993; Warren 1982). Yet such a perspective begs the question of where that common sense comes from. After all, in many institutional domains in the U.S., "common sense" about the mentally ill has allowed them to be defined primarily as "criminals" rather than "patients" (Davis et al. 2012). As such, symbolic compliance in each country requires not just conformity with a particular set of legal procedures and rights, but also an object on which those procedures and rights can be applied.

Judicial Reviews and the Creation of "Serviceable Objects"

My analysis starts with an emphasis on law as embedded in "legal environments," or "larger systems of social beliefs and power relations" (Suchman 2003:127). In both countries, hearings are not held in a vacuum. Instead, they take place within broader mental health systems, which includes both "medical" institutions like hospitals and clinics and "legal" ones like prisons and courts that also process many mentally ill persons. Professionals almost universally understand these systems to be facing competing and seemingly irreconcilable pressures around costs, care, social control, and patients' rights. These contradictions are embodied by mental patients themselves, whose costly, dangerous, or irrational behavior both highlights and exacerbates these tensions.

How do professionals respond to these recalcitrant medical-legal subjects? Hacking (1995:352, 360) argues that expert interventions are often organized around "human kinds"; population groups about which there is "systematic, general, and accurate knowledge" that identifies "laws about people, their actions, or their sentiments" and which provide "principles through which [experts] can interfere, intervene, and improve." As Hacking (1995) and others who use the framework (Eyal 2013) show, such interventions presume that those treated as human kinds will respond in particular ways that confirm the existing classification. Yet what Eyraud (2013:47) calls the "embarrassment" that the mentally ill pose for liberal democratic legal systems and bureaucratic welfare states is precisely that these persons respond neither as normal "medical" patients nor standard "legal" human kinds. As Goffman (1961:379) shows in his classic study, becoming a mental patient is less about becoming an active subject but rather "a kind of object on which a psychiatric service can be performed," a "serviceable object." In effect, in the sense of the constructive power envisioned by Foucault (2008), hearings establish not just the justification for and legitimacy of expert psychiatric intervention, but also the objects of psychiatric intervention themselves (Carlson 2017; Feeley 1979; Holstein 1993; Kohler-Hausmann 2013).

What such an object is, though, must be examined comparatively. Unsurprisingly given differences in their national cultures (Brubaker 1990; Jepperson 1993; Lamont 1995), similar behaviors by the mentally ill are presented as threatening both norms of individual responsibility and personal safety in the U.S. and ideals of solidarity and collectivity in France. Different countries also "make more readily available to its members specific sets of tool through historical and institutional channels" (Lamont and Moody 2000:8–9) with which to respond. For example, French professionals show a greater trust in the capacity of a central state to intervene in society (Dobbin 1994; Fourcade 2009). Americans, on the other hand, are more likely to challenge the privileged judgment of experts and replace it with external tools, from I.Q. testing to computer programs to monitor website traffic, accessible to lay people (Carson 2007; Christin 2018; Porter 1996). Common interventions may take on a different meaning: medication, as I show for example, is a means to further integrate a mentally ill person into the mental health system in France, but render them independent from it in the U.S.

I sum, I argue that hearings are organized by professionals' sense of the gap between the mentally ill persons before them and the mentally ill persons they believe the mental health system should be producing, and the culturally-salient tools—from medicine and law—they have to address them. What constitutes a serviceable object (Goffman 1961) depends on how the legal environment, a product of broader national culture and institutions, create norms about how to balance rights, social control, and care. I do not necessarily insist that these hearings actually succeed in creating people who behave as professionals envision, in the manner argued by Holstein (1993) or Foucault (2008), but only that both professional conflict and legal compliance are oriented towards doing so.

Data and Methods

My primary data consist of observations of hearings on involuntary psychiatric commitment and treatment over a period of three months in both countries. In Paris, most hearings were held in a courtroom inside a single psychiatric hospital, although I attended five appeals hearings at the city courthouse and conducted some comparative observations in a neighboring city.[4] The judges rotated every week and the court-appointed attorney every day; I was thus able to observe dozens of legal professionals performing these roles. All told, I observed 107 hearings.[5] In New York, one judge per week would move between hospitals around the city; I ultimately attended 206 hearings across five different locations. While nearly all hearings in Paris dealt with a single question—whether an involuntary hospitalization could continue—hearings in New York could pertain to the continuation of a hospitalization (referred to as "retention and release" [66]), involuntary outpatient treatment (43), involuntary medication (55), both retention and involuntary medication simultaneous (39), or administrative questions (3).

Fieldnotes from the hearings were coded in the qualitative analysis software Dedoose. When the information was elicited or observed during the hearing, cases were coded for race, gender, age, and diagnosis (see Table 4.1).[6] I also developed a coding scheme that captured key aspects of the hearings, such as the different arguments made in favor of and against commitment.[7] Both sets of fieldnotes were coded twice as a check on the validity and accuracy of my analysis. Relying on observational data has downsides: for example, in cases where the patient did not attend (60 in the United States, 21 in France), I could rarely ascertain their stance vis-à-vis psychiatric care. The

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[4] I was also able to observe some pre-hearing meetings between attorneys and clients, and some judges gave me confidential access to redacted written conclusions.

[5] Patients had the discretion to ask for a closed hearing, and nearly a third did; at the request of the head judge in Paris, I recorded no information about these patients.

[6] In cases where the patient did not attend (60 in the United States, 21 in France), I could rarely ascertain the race of the patient.

[7] For this part of the analysis, I have left out hearings on involuntary outpatient treatment for the U.S., because these hearings were often extremely perfunctory (less than a minute) and had no equivalent in France.

Table 4.1: Patient Demographics and Psychiatric Characteristics

	Paris (n=107)		***New York (n=206)***	
Race	*White* *Black* *Arab* *Asian*	50% 24% 25% 1%	*White* *Black* *Arab* *Asian* *Hispanic*	24% 44% 1% 6% 26%
Gender	*Male*	53%	*Male*	61%
Age	*<30* *30-59* *>60* *Average*	22% 66% 12% 40.8 years	*<30* *30-59* *>60* *Average*	22% 66% 12% 39.9 years
Diagnosis	*Psychosis** *Anxiety/Depression* *Other°*	82% 8% 9%	*Psychosis** *Anxiety/Depression* *Other* *BiPolar Disorder*	83% 1.4% .7% 15%
Prior Hospitalization	*Yes* *No* *Not Mentioned*	51% 11% 38%	*Yes* *No* *Not Mentioned* *Presumed* *Unknown*	70% 6.7% 11.6% 7.9% 1.8%

* For the U.S., "psychosis" includes diagnoses of Schizophrenia, Schizo-Affective Disorder, or Psychosis Not Otherwise Specified. This detail is not given in hearings in France, where BiPolar disorder would be subsumed under the general label of psychosis. ° Includes eating disorders and personality disorders.

advantage of this approach is that, by drawing on direct observation and not written case files, I could focus on the information that was actually evoked in the hearing and used by judges in decisions (Feeley 1979:151; Holstein 1993:32). Although I present side-by-side numerical counts of some codes for each country, the actual meaning of categories like "dangerousness" can only be understood by looking at how they are evoked in context and constructed through national-level policy, professional norms, and cultural schema (see Carson 2007; Fourcade 2009).

Between France and the United States, Paris and New York City represent most similar cases. While the U.S. has only a third as many psychiatric hospital beds per capita as France, for example, New York and Paris have roughly comparable numbers. New York has a high density of psychiatrists—once again, approaching that of Paris—and a robust use of Medicaid funds to provide access to care, suggesting that my findings are not driven purely by the differential availability of psychiatric resources. New York's commitment statutes share with France a wide latitude given to psychiatrists and a relatively late intervention of judges (Behnke, Perlin, and Bernstein 2004). Nonetheless, the features of New York highlighted in Table 4.2—notably, the importance of "dangerousness" for hospitalization—are universal across the U.S.[8]

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[8] Although, as I point out in Chapter 3, "grave disability" or an inability to provide for food, clothing, and shelter is also a criterion for commitment in most states.

Table 4.2: Comparing French and American Medical-Legal Contexts

	France	**United States (New York)**
Context	Crisis due to budget cuts, rise in involuntary care, and pressure to treat psychiatric patients as *dangerous* rather than *diseased.*	Crisis due to psychiatry's inability to monitor, control, and guarantee care to patients; largely invisible use of constraint as lever for accessing services.
Criteria for Involuntary Hospitalization	• "Mental illness that renders the consent of the sick person impossible" AND • "A state that requires immediate care under constant surveillance" AND • Third party demand OR "imminent peril"*	• "Mental illness for which care and treatment in a hospital is essential" AND • "such impaired judgment that he is unable to understand the need for care and treatment" AND • "poses a substantial threat of physical harm to himself or others."°
Introduction of Judicial Review	Made systematic in 2011 under pressure from European institutions and constitutional court; limited patient advocacy.	Expanded in the 1960s and 1970s as part of the broader civil rights movement.
Character of Judicial Review	Automatic after 12 days; limited to "right to come and go."	At demand of patient; deals with "retention and release," "treatment over objection," and involuntary outpatient treatment.
* Another modality, "psychiatric care at the demand of a representative of the state," allows hospitalization in instances of a "infringement of the security of persons" and "grave infringement of public order." ° Can be met by a finding of "grave disability," or inability to provide for food, clothing, and shelter.		

I situate my direct observations within a large literature on involuntary commitments, albeit with most papers dating back decades (see, e.g., Hiday 1977; Holstein 1993; Warren 1982). Rather than attempting to enter the field as a blank slate, I approached observations as an ethnographic "revisit" (Burawoy 2003). A close reading of the existing literature—with some studies carried out in the very same courtrooms in New York where I conducted my observations—allowed me to examine how the same formal legal requirements were applied over time in a radically transformed U.S. mental health system. It also allowed me to examine how similar norms traveled across space, as I could compare the introduction of legal protections for mental patients in the 1970s in the United States with the introduction of similar protections in 2011 in France.

This paper also draws on a subset of my interviews in each country. Here, I focus on transcripts from twenty-four lawyers, three judges, nine psychiatrists who regularly testified in hearings in New York, and seven who worked specifically on public policy and regulations governing involuntary hospitalizations. For France, I center my analysis on interviews with six judges, eight lawyers, eight psychiatrists, and six other individuals working on public policies around involuntary commitments.

The History and Politics of Hearings

France: The Judiciarization of a Parens Patriae Model

France's famous 1838 "Law of Madmen," which mandated that each sub-national department construct or maintain an asylum, makes an easy foil for depictions of psychiatry as a discipline of social control (Castel 1988; Foucault 2008). In truth, though, the law reflected a particular balance of professional power: one modality of internment, misleadingly called a "voluntary placement," would allow psychiatrists to hospitalize persons based on a need for treatment at the request of a third party (usually a family member). Another, "hospitalization by office," permitted agents of the state to confine those deemed a threat to public order. Deliberately excluded from the law were judges, whose claims to be guarantors of Republican rights were superseded by doctors' obligation to deliver effective treatment and the state's duty to protect the collectivity. As the Minister argued, "the measures...relating to [psychiatric] isolation ordinarily demand an extreme rapidity, a prudence, a discretion which are not easily reconciled with the slowness and solemnity of judicial forms" (qtd. in Goldstein 1987:293).

Into the 20th century, among liberals and Republicans it was "pro forma…to denounce [the law's] inadequacies as an instrument for defending the civil liberties and financial assets of the insane" (Nye 1984:33). In total, fifteen pieces of legislation to abrogate the law of 1838 were introduced from 1870 to 1939, most of them centered on requiring the systematic review by judges of hospitalizations. Yet this model proved strikingly enduring. Services outside the hospital expanded in France in the 1960s, but key government decrees and reports make almost no reference to patients' "rights." They speak, rather, of a need to prevent their "social disadaptation."[9] Reform left the 1838 law intact, even as it fell into disuse (Eyraud and Moreau 2013:128). Under this system, the majority of hospitalized patients consented to care, a smaller proportion were deemed incapable of consenting and were hospitalized based on a need for treatment, and a small fraction (in 1986, 3.5%) were placed by the state for threatening public order (Belliard 1990:91). Legal activism around involuntary psychiatric care was minimal: even though patients could insist on seeing a judge, one analysis found that, up until reform in 2011, only 1% did so.[10] One study found only twelve rulings that hospitalizations were "arbitrary" between 1900-1970 (qtd. in Martinez 2016:75; see, also, Guérin 1987:11); a cartoon in a legal review captured these hearings' perfunctory character (Figure 4.1). For psychiatrists, this meant they had enormous autonomy in deciding on involuntary hospitalization: as one recounted, "we could still pretty much apply without asking ourselves any questions. It was enough to…not write random things ("*n'importe quoi*") on the [medical] certificate. The fact that there wasn't any control from the judge, in any case, created a certain kind of automation in medical practices" (Interview, 3/9/16).

By the 1990s, however, the proportion of patients hospitalized involuntarily began to climb (Figure 4.2), prompting parliamentary inquiries and propositions for reform to the 1838 law.[11] Psychiatrists I interviewed blamed progressive cutbacks to the health system and increasingly precarious and socially isolated patients. This situation was, in the eyes of many psychiatrists, exacerbated by a "securitarian turn" that started in 2008 when then-President Sarkozy delivered a speech inside a psychiatric hospital. Responding to a well-publicized murder committed by an escaped patient, he called for psychiatry to play a greater role in "submitting the potentially-

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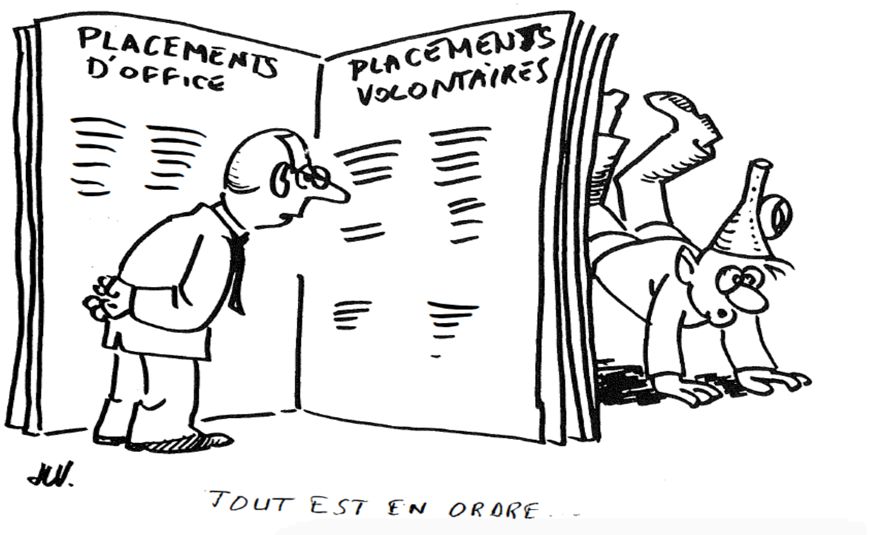
[9] Ministère de la santé publique, *Circulaire relative au programme d'organisation et d'équipement en matière de lutte contre les maladies mentales*: 8.

[10] Legohérel, Delphine. 2014. *Etude sur les soins psychiatriques sans consentement.* Paris: Cour de cassation: 5.

[11] Briot, Maryvonne. 2004. *Rapport fait sur la proposition tendant à la création d'une commission d'enquête sur la progression du nombre d'internements psychiatriques en France.* Paris: Assemblée Nationale.

Figure 4.1: Cartoon Depicting a Judge Visiting a Psychiatric Hospital in France, Stating "Everything is in Order"



Source: Guérin (1987).

dangerous sick to special surveillance."[12] The response of public psychiatric unions to Sarkozy's push was virulent: "it's the only time I've seen the whole profession rise up, to challenge the idea that the mentally ill person is a dangerous one, which was a rupture with the whole approach to mental health since the 1960s," one psychiatrist recounted. Combined with psychiatry's difficulty in delivering accessible care on the basis of a need for treatment, the basis of is legitimacy since the 1960s, the result was that as one *Le Monde* article put it, the discipline, like its patients, was in "great suffering."[13]

The courts injected an unexpected, new requirement into this debate between the administration and psychiatry over the discipline's role and the nature of the people they treated. The absence of a central role for the judiciary pushed French steadily further from the international norm, and over the last decades of the 20th century the country received a third of all complaints pertaining to psychiatry at the European Court of Human Rights (Niveau and Materi 2007). But in 2010, activists from a small anti-psychiatric organization, the *Group Information Asile* succeeded in bringing a case before France's Constitutional Court, arguing that psychiatry constituted "the only case in France where a person can be deprived of her liberty by a simple administrative decision without judicial intervention."[14] The court concurred that the usual justifications for involuntary care—the need to "protect the health of the mentally ill" and "prevent violations of public order"—had to be balanced with the "protection of the rights" of individual patients.[15] The ruling obligated systematic judicial reviews of involuntary care, which a rapidly-introduced 2011 law guaranteed after fifteen (reduced in 2013 to twelve) days of hospitalization.

Legal and medical professionals perceived the change as momentous, but it was also limited. The court allowed a waiting period for judicial review that was much longer than for criminal or

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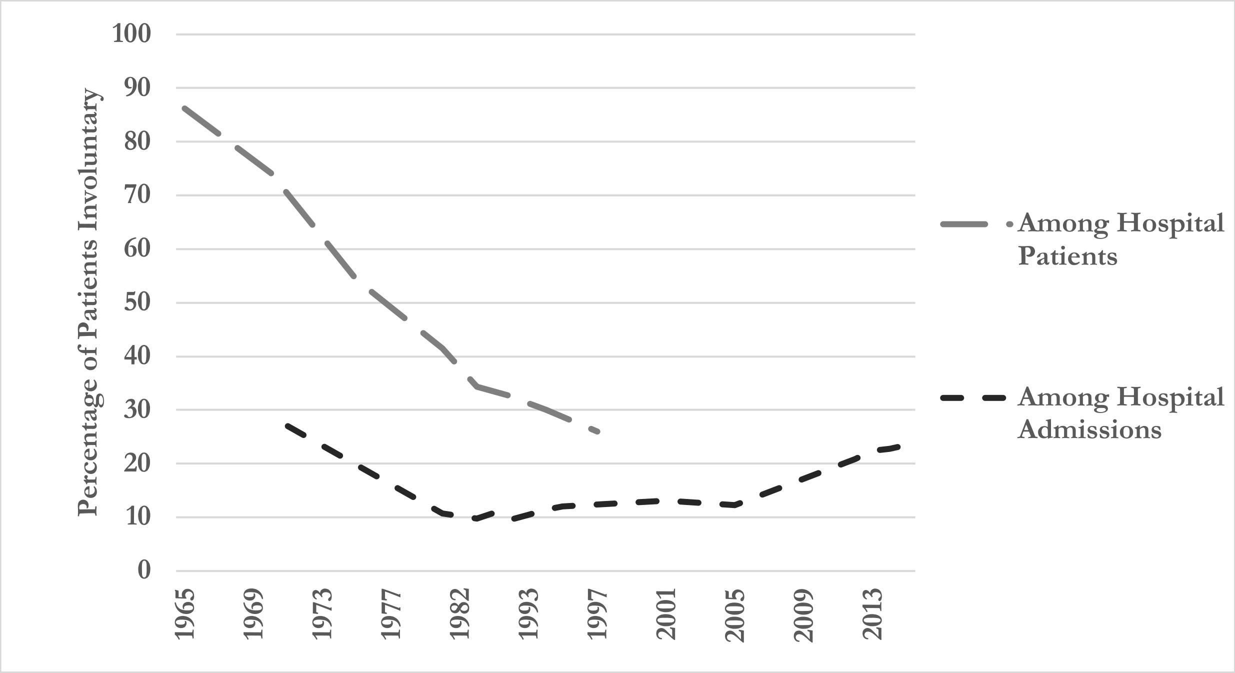
[12] Sarkozy, "Déclaration du Président de la République sur la réforme de l'hôpital psychiatrique."
[13] Béguin, François. January 26, 2018. "La psychiatrie en grande souffrance." *Le Monde*.
[14] Vaillant, Corine. 2010. "Conclusions par avocat de la Groupe information asiles." N° QPC 2010-71. Paris, France: Conseil constitutionnel.
[15] Conseil constitutionnel. 2010. *Décision n° 2010-71 QPC*. Paris, France.

Figure 4.2: Proportion of Public Hospital Patients Placed Involuntarily (France)



Source: Reports of *Commissions Départementales de Soins Psychiatriques.*

immigrant detainees, citing "medical motives and therapeutic aims."[16] The court made its decision based on a person's constitutional right to "come and go": judicial reviews would thus deal with someone's entrance or exit from the hospital. It specifically refused to evoke constitutional articles on personal liberty and privacy that would give it a say on what happened within the hospital walls (such as involuntary medication or the use of restraints). Neither the court's decision nor the law touched the criteria that allowed for hospitalization at the demand of a third party when the person "has a mental illness that renders the consent of the sick person impossible" and is "in a state that requires immediate care under constant surveillance."[17] France remains one of the few Western countries to allow hospitalizations based primarily on *parens patriae*—the state's obligation to care for vulnerable citizens—without requiring that patients be "dangerous" to self or others (Kallert, Rymaszewska, and Torres-González 2007).

Ultimately, the introduction of judicial controls in France was "not the translation of a significant change among medical [or legal] professionals or the evolution of society" but instead "the initiative of a few individuals"—a small group of litigious patients—"using European recommendations in a context of evolving jurisprudence."[18] Yet these controls, seemingly a purely-procedural check on the administrative regularity of medical decisions, gave legal professionals a role in resolving a strident debate over competing conceptions of the mentally ill. Both the administration and psychiatrists supported involuntary treatment, but on the basis of their being risky and dangerous people on hand or suffering and incapable diseased ones on the other. Now, though, both had to engage with patients' status as normal legal subjects.

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[16] Ibid.

[17] Code de la santé publique. Article L3212-1. Retrieved January 20, 2018 (https://www.legifrance.gouv.fr/).

[18] Contrôleur général des lieux de privation de liberté. 2016. *Isolement et contention dans les établissements de santé mentale.* Paris: Dalloz: 62.

United States: Police Power in a Fragmented System

Despite famed jury trials that made the attribution of madness a decidedly juridical matter (see Scull 1989), for most of its history the U.S. made the mentally disordered an exception to liberal norms of judicially-guaranteed rights. Benjamin Rush, a leading proto-psychiatrist of the 18th century, could admit a patient "by scrawling 'James Sproul is a proper patient for the Pennsylvania hospital' on a chance scrap of paper" (Appelbaum and Kemp 1982:344). The Special Committee on Mental Illness and Due Process in New York State (1962:7) described the legal certification hearings for interned patients in the 1960s:

> In the corridor outside, the patients who have requested a hearing, dressed in pajamas and hospital bathrobes, wait in a straggly gray line to present their protests against being 'sent away.' A psychiatrist reads to the judge the physician's report setting out the initial observations and recommendations on the need for care. most patients, when called into the courtroom, talk up in their 'defense'; their stories are sometimes rambling and incoherent, sometimes only a pitiful plea to go home. There is no regular representation of the patient's rights; many observers point out that the hearing may not meet minimum constitutional requirements.

Yet if anything, New York was progressive in patients' rights: one study in Florida found that, 759 commitments, only two went to a hearing (Fein and Miller 1972)

Nonetheless, legal activism was much more visible in the process of de-institutionalization in the United States. Advocates framed this process as advancing the "rights" of the mentally ill, which were in turn defined in negative terms: freedom from arbitrary detention without due process and a liberty to refuse unwanted treatment (Bagnall and Eyal 2016). Gradually, most states reformed their civil commitment laws to take account of appellate court mandates that commitment procedures follow a mixture of protections afforded to criminal defendants (such as the right to counsel) and standards from civil law (a burden on the state to offer "clear and convincing evidence"). They thus sought to render mentally ill persons less a class apart from other citizens. This process mirrored the shift from "specialized" psychiatric hospitals to general ones and the transformation of psychiatry towards the more biological model of mainstream medicine (Horwitz 2001; Strand 2011).

The official statutes in New York State outline criteria for involuntary hospitalizations based on need-for-treatment criteria similar to those in France (Table 4.2).[19] The courts have added another requirement: that a person "poses a substantial threat of physical harm to himself or others" (*Matter of Harry M.,* 568 N.Y.S.2d). In *Rivers v. Katz* (495 N.E.2d 337 [1986]), an appeals court went further, establishing an entirely separate process for involuntarily medicating patients. Within this framework, someone could be found dangerous enough to commit to a hospital but have the "capacity" to refuse treatment. This is unthinkable in France where, as a Ministry of Health directive put it, "there should be no hospitalization without treatment."[20] These rulings clearly shifted the basis of involuntary hospitalization from the state's obligation to care for vulnerable persons ("*parens patriae*") to its prerogative to protect patients and society from harm ("police power").

Coercion today plays a paradoxical role in the U.S. mental healthcare system. On one hand, strict legal protections and the rise of the "recovery movement"—which celebrates patient choice and autonomy—appear to show that "overt use of coercion" has declined (Perry et al. 2018:109). On the other hand, the means of forcing people to care are multiple and expanding. Mental health

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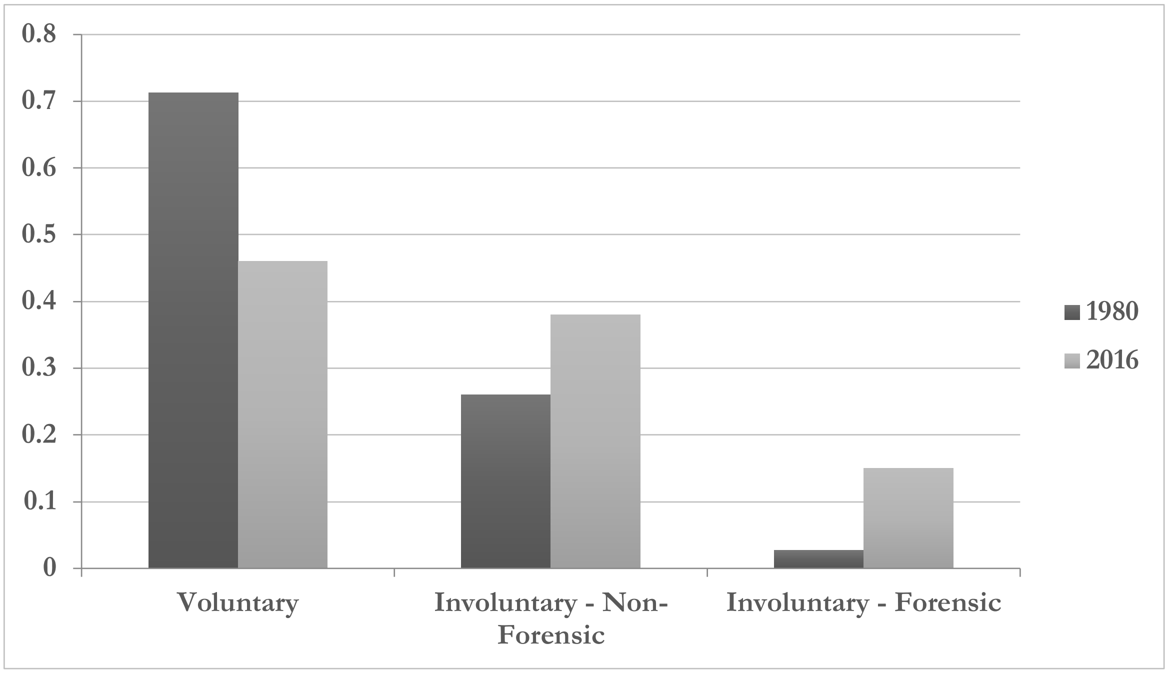
[19] New York Mental Hygiene Law, Article 9.27. Retrieved January 20, 2018 (https://www.omh.ny.gov/omhweb/forensic/manual/html/mhl_admissions.htm).

[20] Direction générale de la santé. "Projet de Recommandation relative à la protection des droits de l'homme et des libertés fondamentales des personnes atteintes de troubles mentaux." DGS - 2009/037- 3.

*Figure 4.3: Inpatients by Legal Status of Admission, 1980 and 2016 (U.S.)**



Source: *Mental Health, United States* (1983) and *National Mental Health Services Survey* (2016).

courts, addiction rehab centers, and police officers mandate people to care (Gowan and Whetstone 2012; Stuart 2014) and incarceration has become one route into otherwise inaccessible treatment (Lara-Millán 2014; Sufrin 2017).[21] New York, in particular, has pioneered the use of involuntary outpatient commitment, under which judges allow patients to leave the hospital but mandate that patients take medication or risk being brought by the sheriff to an ER. Its euphemistic name, "Assisted Outpatient Treatment," is not entirely inaccurate: court orders for AoT apply both to patients *and* providers, obligating private entities to treat and house unruly, unwanted, and expensive patients (Brodwin 2012; Gong 2017). Psychiatrists' power to deliver treatment is, on their own, diminished: inpatient psychiatrists in New York were under such pressure from the managed care companies to discharge patients rapidly that they had little contact with outpatient providers or time to ensure patients left with much more than a prescription (see Chapter 1).

In short, as American states and cities have disinvested in psychiatric hospitals, the status of legal subject carries more rights and entitlements while than the status of mental patient brings fewer and fewer. Coercion is ubiquitous (see Figure 4.3)—my informants estimated that more than half of the 45,000 hospitalizations per year in New York City are involuntary—but it is rarely discussed. The city's comprehensive mental health plan makes no reference to commitments[22] and neither the city nor the state publishes statistics on involuntary hospitalizations.[23] With pressure to move patients through the system quickly, the head of one ER told me, "We don't bother trying to convince people to admit themselves [voluntarily] if they don't want to be here" (Interview,

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[21] One fifth of the hearings I observed in New York were for forensic patients.

[22] DoHMH, *ThriveNYC*..

[23] Records obtained through the Freedom of Information Act from the New York State Office of Mental Health show that 86% of hospitalizations in state facilities are involuntary, but this is a small proportion of overall psychiatric hospitalizations. The state courts system refused a Freedom of Information Act that would have given data on all involuntary care episodes.

11/29/16). Advocates had promised that de-institutionalization would produce "self-reliant, autonomous citizen[s]" (Bagnall and Eyal 2016:42). Once seen as a lever to get patients out of hospitals and into community care, then, judicial hearings on involuntary commitment and treatment are now emblems of the failure of that promise.

The Structure of Professional Conflict in Hearings

Paris: Deference to Medicine

Although France has a historically weak judiciary, the introduction of mandatory judicial reviews in psychiatry by court fiat coincided with an increasingly assertive role for judges in the nation as a whole (see Adut 2004). Yet the Judges of Liberty and Detention (JLDs), typically responsible for authorizing short-term immigration and criminal holds, who were tasked with the hearings were reticent to take on their new role. As the head JLD of Paris explained:

> Whenever there's a new law, the judge is going to ask the question: why am I competent here? Why do we need a judge? Judges don't intervene in everything—if we did, we'd never do anything important! So at the start [after the law of 2011] we were asking, 'Why am I going to authorize a hospitalization that was decided upon by a doctor, even though I have no training in psychiatry?' Okay, the law says I'm going to intervene…but why? Judges are supposed to resolve some conflict, but often I don't see any conflict (Interview, 5/12/16).

Although the role of the judge was to evaluate the procedural regularity of a form of detention, the judge defined the key issue—is the person ill and needing treatment?—as decided in advance.

Indeed, despite their formal mandate, the organization of the hearings made it difficult for judges to carry out their typical role in France as investigators and inquisitors (see Decker 1987; Heimer 1999). For a start, psychiatrists had the prerogative to declare their patients "non-presentable" for the audience, which they did in 25% of the hearings I observed. Sometimes, they did so for reasons that had a compelling legal logic: "risk of fleeing and placement in danger; currently in an isolation chamber and under mechanical restraints." At other times, though, they boldly asserted medical prerogatives: as one psychiatrist wrote to the judge, "the patient is able to attend, but this would imply excess stimulation that would disturb the therapeutic improvements that are taking place." In New York, patients "refused" to come to hearings; in France, the choice was attributed to the psychiatrist.

French lawyers and judges did not review the entire medical dossier, but instead saw only medical certificates psychiatrists (begrudgingly) wrote on the first, third, and eleventh day of hospitalization. Judges often copied and pasted these medical certificates into their written rulings. One judge who confided she had no knowledge of psychiatry nonetheless wrote that "patient presents a mediocre contact with agitation; tachyphrenia and verbal diffluence; disassociative and discordant delirium, with minimal construction; persecuted and megamaniacal; anosologia with morbid rationalization." Because the law did not require psychiatrists to attend the hearings, no one could ask them to explain or elaborate the often very limited facts before the court, or even explain the terminology judges were themselves appropriating. When one lawyer disputed the claims in one certificate, the judge replied, "Look, I'm not a doctor, so if the medical certificate says that's the state of the patient, that's it. *Voilà*."

As I learned at a training for lawyers, their best strategy was to identify one of over one-hundred possible errors in the procedure, such as whether patients were presented with certain pieces of paper or when certificates were transmitted to various public authorities. One lawyer explained the logic behind this approach:

> My work doesn't stop the person from being cared for. I just want the law respected in the case of a privation of liberty. It should be 'in conformity' and respect the law. I'm okay with

> people being constrained to heal them, but the constraint needs to be procedurally correct. I mean, 95% of the people in the hospital, they ought to be there (Interview, 7/8/16).

As he insisted, arguing vigorously did not mean questioning the labeling of his clients as mentally ill or the prerogative of the state to treat them. Another explained, "I always tell my clients, 'I'm not a doctor, the judge is not a doctor, we're not here to talk about the treatment, but just check on the procedure.'" From this perspective, the limited information available to lawyers seemed less of a problem. One of the few lawyers with extensive experience litigating mental health cases prior to 2011 told me, "I don't know what I would do with a medical dossier, really. I don't know anything about medications, I don't know their dosages" (Interview, 5/12/17).

The three cases where I saw a measure of hospitalization lifted entailed just such procedural issues: in one case, the readability of a signature, another the timing of an administrative document, and in the last the appropriate stamp on two forms. None of these put psychiatric evaluations or expertise in question. For most judges, though, releasing people on these grounds meant losing sight of the special status of mentally ill persons:

> Sometimes, the lawyers don't understand that it's health we're talking about here, not defending someone against an infraction. So they'll look for a procedural problem, and I might be forced to lift the hospitalization, even if we know the person is going to walk outside and commit suicide. And I'll ask, 'You know he's going to throw himself in front of a car?' and they say, 'Yes, but there's an irregularity!'

Despite the judge's complaints, many lawyers had the same view. A lawyer that same day told me, "I'm not going to be the one to get someone out if they are just going to commit suicide. Some of my colleagues will do it, but, I'm sorry, I want to be able to sleep tonight." As shown by Table 4.3, lawyers only made a clear argument on behalf of their client forty-percent of the time.

In their reluctance to challenge psychiatry's jurisdiction and deference to prior determination that patients were mentally ill, French legal professionals took positions that resemble those described by literature on hearings on involuntary commitment happening in the United States shortly after they were introduced (Decker 1987; Hiday 1977; Warren 1982). In some cases this was a sign of listless symbolic compliance with a law in which judges and lawyers took little interest. I find, however, that it also reflected a positive set of beliefs about what the hearings should be: a non-adversarial check on the administrative regularity of a decision. Even the most active lawyers, some of whom fought zealously for their clients, and the most interested judges, who listened attentively and crafted carefully worded decisions, nonetheless accepted that the status of the person before them was to be defined by psychiatry and not law. They then acted in ways that stripped agency from a person they saw more as a medical object than legal subject.

New York: The Dominance of Law

French policy consistently presumes that the mentally disordered are "incapable of formulating a demand,"[24] and thus deemed that hearings should take place automatically after twelve days. In New York hearings are held only at the demand of patients, a sign of the greater self-advocacy the system demands and the assumption that they can assert their rights in spite of a presumed mental illness.[25] This demand is facilitated, however, by a dedicated service of lawyers—the Mental Hygiene Legal Service (MHLS)—which contacts patients immediately after their admission, negotiates with psychiatrists and administrators on their behalf, and can litigate over both

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[24] Chossy, *Rapport sur le projet de loi pour l'égalité des droits:* 37.

[25] Less than 20% of involuntary hospitalizations lead to a hearing, in part because even involuntary patients are quickly discharged anyway (see Shea 2012; for California, see Warren 1982:56).

Table 4.3: Lawyers' Stances During Hearings

	Oppose Hospital w/ case-specific argument	Oppose Hospital w/o case-specific argument	Statement w/o Clear Opposition or Support	Support Hospital against client	Support Hospital with client	No argument
Paris	22.8%	9.7%	15.2%	16.3%	21.7%	14.1%
New York	83.6%	9.8%	0%	0%	3.3%	3.3%

the hospitalization itself and the conditions under which it takes place. Because MHLS serves only mentally disabled clients and its lawyers have full access to wards and medical records, it has been described as the gold standard for patient advocacy (Decker 1987:169; Perlin 1992:44).

Although legal scholars have argued over whether attorneys should substitute their (and psychiatrists') assessment of the "best interests" of clients in place of their stated preferences (Cook 2000; Perlin 1992), MHLS attorneys clearly refused to do so (Table 4.3):

> We represent peoples' stated interests, not what we or someone else think is their best interest. I think we really have to be dedicated to that. Even if it's someone who is in a psychotic episode, totally delirious, it can be hard to figure out that preference or it can change all the time, but that's what we work with. It's true that sometimes, we know, 'That's not going to be a winning argument,' but we take it anyway (Interview, 12/16/16).

These lawyers saw themselves as on an equal footing with their "adversaries," the hospital and its psychiatrists. When I asked one lawyer if she felt limited by her lack of medical training, she replied:

> I would say that there's no boundary…to what our attorneys can ask the doctors. We have an obligation to represent our client's position zealously, and thoroughly, and so I think anything that is at all relevant to the proceeding is on the table (Interview, 12/28/16).

For MHLS lawyers, psychiatric expertise was hardly expertise at all. "This [diagnosis and treatment] is absolutely something non-psychiatrists can understand," that lawyer elaborated.

Judges, too, scoffed when I asked if they felt uncomfortable calling into question medical prerogatives. As one judge told me:

> Absolutely not. I let people out. Don't ask me to keep someone in a confined space, and maybe even given the psychotropic medication against their will, unless you're going to give me some real reasons. I don't assume that just because someone is in a psychiatric hospital, they 'must have done something.' It's just like a criminal case: you can't say someone is guilty just because they got arrested (Interview, 12/6/16).

I asked another judge if this was a "special" kind of law for which special training was required, and she told me, "No. Law is law." But, she added, "I need the MHLS attorneys"—not a psychiatrist—"to tell me if a medication is contra-indicated." These comments are consistent with decades of critiques of psychiatric expertise for its arbitrariness, unreliability, and lack of predictive power (Craciun 2016; Strand 2011).

Unsurprisingly, the most frequent arguments mobilized by MHLS lawyers were those that directly contested whether the patient met legal criteria for hospitalization or involuntary medication (Table 4.4). Yet more striking was the frequency with which they used arguments that de-legitimized psychiatry and psychiatric treatment. Lawyers were more likely to argue that treatment would be ineffectual in altering the patients' behavior than to claim that it had been effective enough that the

*Table 4.4: Legal Arguments for Release / Denial of Treatment Over Objection**

Arguments Based on Legal Criteria			**Argument Based on flaws in psychiatry, procedure, or treatment**		
	New York	***Paris***		***New York***	***Paris***
Willing to Take Treatment	39% (59)	46% (22)	***Alternative Explanation for Behavior***	28% (43)	10% (5)
Not Dangerous	37% (56)	17% (8)	***Side Effects***	27% (42)	8% (4)
Capable of Surviving Outside	26% (40)	2% (4)	***Treatment / Hospital Ineffective***	18% (28)	0% (0)
Less Restrictive Alternative	21% (32)	N/A	***Alternative Diagnosis***	15% (23)	0% (0)
Not Severe / Improving	16% (15)	27% (13)	***Lack of Information / Justification***	9% (14)	21% (10)
Work / Family / Life Outside	0% (0)	29% (14)	***Procedural***	1% (2)	32% (15)

* Analysis based on all hearings in which the attorneys made an argument or statement in favor of release of patient. N = 151 for New York, 47 for Paris.

patient could leave. In one hearing about involuntary medication for a patient who had been transferred from the city jail, the attorney challenged:

> *Patient's Attorney*: He can get medication at the jail, can't he?
> *Psychiatrists*: Well, some medications, but not all of them…
> *Patient's Attorney*: But it's true that no matter which medication you offer some people, they're never going to 'gain insight'?
> *Psychiatrist*: I suppose that's true…
> *Patient's* Attorney: So maybe this is just his baseline and you can't change it?

I followed up with that lawyer after the hearing, and asked him if he was concerned about the person going un-medicated:

> I'm not allowed to think about the consequences of a discharge. If someone is going to be on the street, that's not something I can consider…You can't factor in that someone is going to go on the street if you let them out. I mean, after two more weeks, they're still going to go on the street, and they're still going to stop complying with their medication anyway (Interview, 12/13/16).

As he saw it, psychiatry was simply unable to offer his clients more than a temporary "synthetic sanity" that they would ultimately abandon, with side effects greater than the benefits it could bring.

Previous research found that even with aggressive lawyers and judges "the diagnosis is never directly challenged" (Holstein 1993:xviii; Warren 1982:140). But present-day MHLS lawyers actually cast doubt on the very labeling of mental illness, as in the case of a young black man whose family brought him to the ER:

> *Patient's Attorney*: You said he voiced delusional content in the ER?
> *Psychiatrist*: Yes.
> *Patient's Attorney*: But you know he is a regular marijuana smoker, right?
> *Psychiatrist*: Yes
> *Patient's Attorney*: And now he's refusing to speak to you, so it's fair to say you have no idea what his current symptoms are?
> *Psychiatrist*: Well, he's guarded, he has flat affect, he seems internally preoccupied… it's consistent with psychosis.
> *Patient's Attorney*: People can have a 'flat affect' and be 'internally preoccupied' without a thought disorder, isn't that right?

Although in theory these lawyers could advocate for their clients to receive more care—a high-intensity outpatient team or medicalized housing—they rarely did. Their alternative diagnoses of their clients' problems as stemming from substance use, dementia, or physical illness were instead arguments for freedom from psychiatric intervention.

MHLS lawyers' challenges to psychiatric expertise took place in public, and all present witnessed a ritualized enactment of courtroom procedures: the admission of evidence, qualification of experts, and direct and cross-examinations. The legal identity of the person before the court came not just through giving them access to a 'normal' legal setting, but also through the assertion of legal prerogatives over medical ones. In one situation, a lawyer referenced her client, a black male in his forties whom the psychiatrist had testified was not capable of caring for himself outside the hospital:

> *Patient's Attorney*: Does he look clean, well-groomed, well-dressed?
> *Psychiatrist*: Yes but…
> *Patient's Attorney*: And that was true at the examination when you first saw him?
> *Psychiatrist*: Well…
> *Patient's Attorney*: So he has a place to take care of himself, even if *you* don't know where it is?
> *Psychiatrist*: Sure, but the issue is…
> *Judge*: Don't try to tell the court what 'the issue' is. Just answer the questions. I can figure the 'issues' out myself.

Even though they nearly always ruled substantively in favor of hospitals, in a quarter of cases judges also made minor and (to psychiatrists) arbitrary modifications to their requests, like striking one or two medications from a list the psychiatrist was authorized to administer or setting a time limit on the hospitalization. Judges obligated psychiatrists to sit patiently, sometimes for hours, for their turn to testify, rather than letting them come and go from the courtroom (which was, after all, in a hospital where at least some of them worked). If the judge left before the docket was completed, a psychiatrist might have to wait another week for a response on requests for involuntary medication, which usually meant they would simply discharge a patient that they were unable to treat.

Although they ultimately facilitated the exercise of psychiatric power on unwilling patients, legal professionals contributed to a very different narrative of the purposes and aims of public psychiatry. A judge described himself as torn between different legal ends:

> As a judge, my main goal is to apply the law fairly. That means that the burden has to be met, either by the state, or by the hospital. The most concerning thing for me is whether the person is a danger to themselves or others. That's really what worries me. At the same time, I don't want people to be medicated unnecessarily, or confined unnecessarily, because that brings up questions of due process and liberty (Interview, 12/6/16).

In weighing the protection of rights versus the protection of society, the judge left out what was at the front of French legal professionals' mind: the patient's health or illness.

Table 4.5: Patient Stances During Hearings

	Oppose – Any Treatment	Oppose – Hospitalization Only	Oppose – Conditions / Medication	Ambiguous	Consent – with Solicitation	Consent – Without Solicitation	Not Present
Paris	15%	20%	7%	10%	15%	8%	24%
New York	44%	26.4%	7.7%	0%	1%	4.4%	15.4%

The Process of Symbolic Compliance

Paris: Affirming a "Right to Care"

In Paris, patients outright refused all measure of psychiatric care offered them relatively rarely (only 15% of cases) (Table 4.5). Most hearings took place within a grey area where the actual preferences of the patient were not clear either in testimony or the medical certificates, the latter referring twice as often to "ambivalence" towards care rather than "opposition." In such cases, judges positioned themselves not as neutral arbiters, but as active proponents of accepting care. This was evident in the very words that judges used to explain the hearings. One week, for example, every hearing began with the statement, "I'm the judge who will decide on your hospitalization. Your doctors say it's a bit early for you to leave. Are you willing to trust them and stay a bit longer?"

Judges were obstinate in seeking peoples' consent to measures of constraint they clearly planned to leave in place anyway. A 35-year-old Black woman—picked up by the police for shouting in the street and whose doctor determined had stopped her anti-psychotic treatment—stated, "I'm doing better, I don't need to stay." The judge pressed:

> *Judge*: Yes, your doctor said that you were doing better, and you can leave soon to your house. You want to go home, don't you?
>
> *Patient*: Yes.
>
> *Judge*: Great. You *are* going to go home, but you should only go home when you're in good health. Your son needs a healthy mother. He's how old?
>
> *Patient*: Fourteen.
>
> *Judge*: Well, he's going to take the *brevet* [a national test taken prior to high school] soon. He'll need you to be doing well to help!

The woman eventually stated, "I don't want to stay too long…" to which the judge enthusiastically replied, "Okay. I'm going to *let you* continue with your hospitalization, then" [emphasis mine].

Even aside from cases where lawyers supported a measure of constraint that their clients were opposing (see Table 4.3), lawyers also participated in eliciting consent. One dialoged with a person with chronic schizophrenia who was hospitalized after he failed to show up for his monthly injection:

> *Attorney*: Do you want to stay in the hospital and consolidate things, as they're recommending?
>
> *Patient*: I like to take things slow, but I think I'm ready to go.
>
> *Attorney*: So you don't agree with the doctor? Are you sure?
>
> *Patient*: No… [Lawyer sighs]. I only want to leave under good conditions! If I leave, they're going to put me out with nothing but slippers!

When the lawyer appeared in front of the judge, she nonetheless declared, "*Monsieur* wants to leave, but he also trusts his doctors." The final opinion from the judge noted that he "did not oppose the continuation of his hospitalization…his lawyer specifying that he trusts his doctors and prefers to wait to be better before leaving."

Why bother seeking consent from people who would remain in a "hospitalization without consent"? The answer stems in part from the peculiar French definition of what "without consent" actually means. In a European debate over recommendations around the rights of psychiatric patients, France objected to proposed criteria for involuntary care that required that "the person in question does not consent to placement [in a hospital]." The delegation replied that this proposal "did not respect the principle of consent that is a fundamental principle of French law."[26] Reading carefully, French law allows hospitalization when the person's illness "renders consent…impossible," not when the patient withholds consent per se. While judges frequently evaluated whether the person was "consenting" in other domains, determining the *ability* of a patient to consent was strictly medical. As the judges' training manual declared, "consent given at the audience has no value."[27]

No *legal* value, that is. In seeking consent from patients, judges were not looking for a reason to withdraw legal constraint. Instead, they acted based on a moral rather than legal imperative to convince patients of the need to self-identify as mentally ill and accept the long-term relationship with psychiatry this implied. When a retiree repeated that the anti-depressants she was given were having no effect because her problem was not an illness but that her husband was dying of cancer, the judge replied:

> You're in a severe depression and you don't see the pathological dimension of it. Most of the treatments for depression don't function before fifteen days, so it's normal that you don't feel better yet. It's a chemical thing. The medicine hasn't expressed itself yet.

As she explained to the woman, "It's like diabetes. Some people have to take a treatment every day for their whole lives. It's not fun, it's not easy, but they accept it and move on." Even though she admitted she never released patients, the judge explained that the audiences were useful because "I think there is a pedagogical value, to talk about the value of treatment."

By validating an "inability" to consent rather than a "refusal" to consent, French law partly made involuntary hospitalized patients into objects consistent with the psychiatric profession's stated commitment to voluntary care. Post-war French psychiatry, heavily influenced by psychoanalysis, argued that through long-term therapeutic relationships nearly all patients would come to "demand" psychiatric care (Roudinesco 1990). This demand marked their permanent inscription into France's universalistic, free public mental health care system. The law always allowed a work-around, though, permitting a "third party" to demand a hospitalization in the patient's place—a procedure that still protected psychiatrists from claims that they, alone, were imposing care.

In the contemporary context, however, public psychiatrists faced with budget cuts and an increasingly precarious patient population found it harder to develop long-term relationships with patients or find a third party such as a family member, leaving them with no demand to which to respond (Lafaye 2016:50). By becoming the new third party, judges could preserve the doctor-patient relationship because it was they, not the psychiatrist, who imposed care. It was thus not absurd for drafts of the 2011 law to declare that the goal was to "remove obstacles to care,"[28] even though similar laws instituting judicial review in the U.S. were explicitly attempts to throw up

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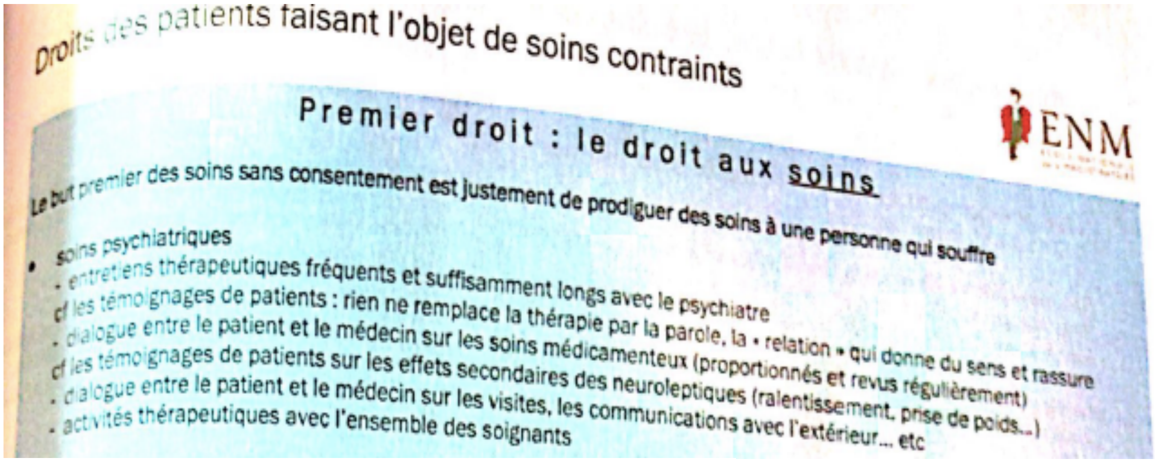
[26] DGS, "Projet de Recommandation."

[27]

[28] Bachelot-Narquin, Roselyne. 2010. *Projet de loi relatif aux droits et à la protection des personnes faisant l'objet de soins psychiatriques*. Paris: Assemblée Nationale: 3.

Figure 4.4: First Page of Judges' Training Manual (France)



Droits des patients faisant l'objet de soins contraints

Premier droit : le droit aux <u>soins</u>

Le but premier des soins sans consentement est justement de prodiguer des soins à une personne qui souffre

- soins psychiatriques
  - . entretiens thérapeutiques fréquents et suffisamment longs avec le psychiatre
  - cf les témoignages de patients : rien ne remplace la thérapie par la parole, la « relation » qui donne du sens et rassure
  - . dialogue entre le patient et le médecin sur les soins médicamenteux (proportionnés et revus régulièrement)
  - cf les témoignages de patients sur les effets secondaires des neuroleptiques (ralentissement, prise de poids...)
  - . dialogue entre le patient et le médecin sur les visites, les communications avec l'extérieur... etc
  - . activités thérapeutiques avec l'ensemble des soignants

Source: ÉNM. *Soins psychiatriques sans consentement.*

obstacles to it. This fiction helps to explain the "complete satisfaction"[29] that major psychiatric unions announced they felt with respect to the judicial intervention introduced by the 2011 law.

Ultimately, judges were working to comply with a particular understanding of what that person's real "rights" were. As the training packet for new judges explained on its first page: "The first right: right to *medical care* [emphasis theirs]" (Figure 4.4). Another legal article elaborated:

> Neither administrative detention, nor imprisonment, nor provisional holds has as its object the well-being of the concerned person. That is the difference with hospitalization under constraint: the infringement on the freedom to come and go is decided based on the interest of the patient (Giloux and Primevert 2015:973).

Similarly, a set of guidelines on the criteria for hospitalization declared, "it is the absence of care that creates prejudice against patients…not putting them in place in an authoritative manner."[30]As one judge told me after a long day of hearings, "The people we saw today, they were all people who were not doing well. They're going to have to leave in a few days but for now they're getting care, so there's no reason to release them." In her view, hearings confirmed both a need and provided a demand for care; they affirmed a legal right to medical treatment in a public psychiatric system where budget cuts had restricted that right's practical exercise.

New York: Legal Cover for Social Control

As legal advocates, appellate judges, and rights-minded legislators in the 1970s envisioned, involuntary commitment hearings in New York resembled the adversarial process of criminal trials. Lawyers' engagement and judicial assertiveness have clearly intensified relative to the procedures reported on by previous sociological work (see, e.g., Decker 1987; Hiday 1977; Warren 1982). Paradoxically, though, legal advocacy actually showed a need for interventions to control patients and established that hospitals had complied with legal criteria, even as psychiatrists' capacity to provide an expert basis for this was constrained.

Nearly all hearings began with an apparent "victory" for patients: the exclusion of second-hand information acquired by the psychiatrist. The following excerpt is typical:

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[29] Mauduit, Hélène. November 26, 2010. "Psychiatrie: réactions à l'inconstitutionnalité partielle des hospitalisations à la demande d'un tiers." *Dépêche APM.* Retrieved June 26, 2017 from http://goo.gl/od7UP.

[30] HAS, *Modalités de prise de décision*: 27.

Hospital Attorney: Please explain the circumstances under which the patient was brought to the hospital.
Psychiatrist: The patient was brought in by EMS [Emergency Medical Services] after a call from her mother, who said they had been fighting and she was…
Patient's Attorney: Objection, hearsay.
Judge: Sustained.
Hospital Attorney: Could you describe the patient's behavior in the ER?
Psychiatrist: Well, she was talking about her mother and…
Patient's Attorney: Objection, hearsay.
Judge: [interrupting psychiatrist] Were you actually there? Just tell me what you've seen on your unit.

The court's refusal to allow psychiatrists to testify about the little they could glean about patients' histories accentuated what both judges and lawyers frequently remarked was the psychiatrists' limited knowledge about patients they were treating.

Yet in valorizing patients' right to privacy, the court also stripped away context. By directing psychiatrists to "just tell me what you've seen," the court prompted doctors to present patients as bundles of symptoms with no reasons behind them. Privacy can be turned against the patient, as the following excerpt from a hearing for a young man who had been refusing to talk to clinicians while in the hospital shows:

Judge: So what's really going on here? It sounds like mostly drug use…
Psychiatrist: We think it's a first-break psychosis.
Judge: So do you think it's a *clinical* problem that's explaining his behavior?
Psychiatrist: Well, he's very paranoid…
Judge: And there's nothing in his history that might explain this?
Psychiatrist: We don't know. He won't let us talk to anyone.
Judge: If there's no other explanation, then, the application [for the patient's release] is denied.

Lawyers' objections wiped away any backstory that might explain why, for example, a young woman with an extensive history of unsuccessful psychiatric treatment was "refusing oral medication" and "required an intravenous injection," or why a formerly-incarcerated black male was "paranoid that the police are out to get him."

As the judge directed them, most testimony from psychiatrists about patient dangerousness vis-à-vis others was based on actions *within* the hospital, not outside it (Table 4.6). There, all activities were presumed to be a manifestation of illness. Goffman (1961:37) referred to this as "looping," in which "the inmate's reaction to his own situation is collapsed back into this situation itself." Fights with roommates or unsuccessful visits with family, for example, became manifestations of the need for hospitalization rather than—as many patients vigorously protested—a reaction to it. When a patient accused the police of filing a false report in order to get him institutionalized, the lawyer representing the hospital queried:

Hospital's Attorney: Does he say that because of the symptoms of his mental illness?
Psychiatrist: Yes, he has very poor insight into his condition.
Patient's Attorney: He actually doesn't deny the initial event, he just says that the report misrepresented the circumstances.
Psychiatrist: Yes, he has a great 'mentalization' of the event.

What in a "normal" criminal hearing might be an open question—was a defendant's challenge to a police report valid?—actually became evidence in favor of a ruling against the patient, because the challenge itself was a symptom. One psychiatrist even testified that the patient's paranoia manifested

Table 4.6: Basis of Patient 'Risk of Harm' or Dangerousness in New York

	Outside	***On Unit***
Threat - Others	14	45
Threat - Self	9	5
Violent Act - Others	15	38
Violent Act - Self	11	5

itself in a "fixation on the legal conditions for his hospital, such as asking us to explain the procedure for his admission several times."

A final example of how legal processes buttressed medical conclusions could be seen when patients themselves took the stand. In some instances, attorneys did their best to avoid calling their clients to the witness stand because judges were reticent to release patients who did not meet the requisite legal standard of "dangerousness" yet who were nonetheless plainly mentally ill. Hospital attorneys themselves played into this by posing seemingly impossible questions:

Hospital Attorney: Why did you come to the hospital?
Patient: Uhh… because they brought me here.
Hospital Attorney: But why did they do that?
Patient: I don't know. I was in a washroom.
Hospital Attorney: But why do you think they thought you needed to be here?
Patient: Why don't you ask them? I was minding my own business.
Hospital Attorney: Well, not everyone winds up in a psychiatric hospital.

Under pressure, the patient grew progressively more hostile and aggressive, and a judge who had seemed favorable to her release eventually ruled to keep her in.

The way patients' right to privacy, behavior on the ward, and testimony were turned against them confirms how, in lower-level courts in the United States, evocation of rights entails serious costs that can be avoided by "suffer[ing]…in silence" (Feeley 1979:33)—in this case, quietly taking treatment and waiting for release. This process was crucial in a system where psychiatrists spent ever-diminishing time with their patients, had less information about their lives outside the hospital, and needed to medicate and discharge patients quickly despite legal hurdles to doing so.

The Production of "Serviceable Objects"

Paris: From Dangerous Madmen to "Suffering Citizens"

In addition to hospitalizations based on *parens patriae*, France also allows "hospitalizations at the demand of a representative of the state" when someone, as a result of mental illness, "compromises the security of persons or public order" or constitutes an "imminent danger." In the twenty-four cases of involuntary hospitalization based on the state's police power I witnessed, French psychiatrists mostly did at least symbolically abide by the "imminent danger" or "compromise [of] the security of others" criteria, with seventeen hearings involving some explicit reference to "threats," "dangerous acts," or an evaluation of "risk."

Yet the actual written decisions justifying prolonging care often made no reference to these factors. For one young black man who was stopped outside a train station brandishing a knife, the decision elided the question of danger entirely: "*Monsieur* suffers from a delirium and hallucinations in a context of troubles with his mood since last autumn. He only partly understands the pathological character of his troubles and his need for treatment." While Foucault (2008:220) claimed that, in 19th century France, psychiatry consolidated its power when it adopted "the notion of danger" to "transform an act of assistance into a phenomenon of protection," hearings did the opposite. Risky behaviors were replaced by symptoms, and the protection of society became assistance to the individual.

In rare cases, the police prefecture saw sufficient interest in keeping a person interned to send its own lawyer. In one such instance, that lawyer responded to a fierce argument from the patient's lawyer that "no risk to the public order has ever been shown" by declaring:

> *Police Attorney*: I want to re-center the debate. Does she need care or not?
>
> *Patient's Attorney*: Wait, it's not that at all! She never aggressed anyone. When she went to the police to complain about her neighbors, they simply said they 'detected suffering' and hospitalized her.
>
> *Police Attorney*: Again, let's look forward: is she going to take medication on her own? We have four doctors saying she needs treatment. We have to do something!
>
> *Judge* [to patient]: You need to understand that we're not in a penal situation here. It's not about guilt. [Speaking to all] We have here a woman who isn't doing well and we need to figure out what is best for her. That is the spirit that will guide my decision.

Previous socio-legal research suggests that, in contexts of limited time and information, judges in civil cases tend to lean on heuristics drawn from the criminal justice system (Carlson 2017; Ryo 2016). Yet when I mentioned the more adversarial and criminal-style proceedings in the U.S., the judge told me, "That's absolutely awful. These are people who are suffering and vulnerable. You put them in a room with everyone looking at them and they will just crumble."

Another case confirmed that some variant of "dangerousness" was not the key criterion for decision-making—even though, legally, it was. The judge read a report from the psychiatrist that talked about a woman who had "threatened her neighbors with a deadly weapon." The hearing revealed that this characterization was exaggerated, but the judge left her in anyway:

> *Judge*: They made it sound like she was really dangerous, and was on the edge of chasing someone down with a machete. But it sounds like she was dirty and incoherent, but she wasn't dangerous at all.
>
> *Interviewer*: Then why leave the measure in place?
>
> *Judge*: We have patients that are dangerous, but even for them, the law is about what's in the interest of the patient. And even for the dangerous ones, there's always an interest in getting them into care. But mostly, what we have isn't that… it's people who are depressed, maybe a little bit delirious, but who have just lost it and need help.

To highlight that she did not see keeping people in hospitals as about containing dangerousness, she told me, "When I do the [criminal] detentions, I let dangerous people go all the time, and I don't bat an eye. But here it's a different kind of law."

What kind of law was it, then? The answer lies in the very kind of person these hearings deal with: "above all, people who suffer" (Giloux and Primevert 2015:982). To many, as one psychiatrist told me, "there's no such thing as a 'dangerous patient'" (Interview, 5/12/16), only patients who engage in dangerous behaviors at a given moment and who need to be constrained temporarily to allow psychiatrists to do their work. Someone who is simply violent, *tout court,* is not a real *malade*. Judges followed this reasoning by centering on pathology and putting "dangerousness" aside; in so doing, they also set aside the procedural and due-process legal rights that would apply in a penal setting. As one judge explained:

> For the law to permit such an infringement on the rights of persons, there has to be another, more important right to justify it. And that's the right to the protection of health. The law says, 'For someone who needs care but cannot demand it, the state must step in to organize care' (Interview, 4/26/16).

In short, having accepted psychiatrists' characterization from the outset—that the persons were suffering—judges insisted on the one right of citizens that clearly flowed from it: the right to care.

The state "organizing care" was about much more than medication. Both medical certificates and judicial opinions emphasized that hospitalizations could be prolonged so that, as one wrote, "gains can be consolidated, and the doctors have sufficient time to construct, with the patient, a structured project for discharge, which will permit the patient to progressively return to a normal life, stabilized and in safety." Even though nearly everyone recognized that the system was in crisis, hearings nonetheless affirmed that these suffering citizens would receive ongoing solidarity from the welfare state, extending beyond medical treatment to housing, aid in daily life, and, at times, even help with employment. They just needed to recognize their suffering and, gradually, accept it.

New York: The Rationality of "Compliant Calculators"

In *O'Connor v. Donaldson* (422 U.S. 563 [1975]), the Supreme Court ruled that a mentally ill person should not be confined "if they are dangerous to no one and can live safely in freedom." The hospital attorneys knew that meeting this standard was crucial. Before one hearing, I heard one counseling the psychiatrist, "I need you to emphasize that she's *dangerous*." The seventy-three-year-old woman came in on a walker and the psychiatrist recounted allegations that she sprayed a neighbor with Windex.

In private, most psychiatrists recognized that their ability to predict which of their patients was actually dangerous was poor (see Glied and Frank 2014).[1] Rather than rejecting professional assignment to assess and police dangerousness, though, most were resigned to this nonetheless being their role. One clinical director at a public hospital admitted:

> We get a lot of people transferred from the criminal justice system. What I tell my staff is, 'just like we use universal precautions against infection, assume everybody is violent until proven otherwise.' So assume that anybody's capable of hurting anybody else or hurting themselves, because you can't sort it out (Interview, 1/7/17).

As another told me, "psychiatry is the police. We should just be honest about it" (Interview, 12/14/16). Indeed, in hearings, references to dangerousness were omnipresent, even to the point of seizing on patently marginal details:

> *Psychiatrist*: The patient actually came in himself for an eye injury, but was transferred to psychiatry because he was speaking in sentences that made no sense. He claimed that he was an actor in the play 'Clockus', that he had seven daughters and seven spouses, and that he wanted a diagnosis with 'more texture.' He was also making non-sensical rhymes, such as he was 'born in dorn'.
>
> *Hospital Attorney*: And does that eye injury show that he is in danger?
>
> *Psychiatrist*: [pause] Uh… yes, if he doesn't take medicine for it, he could get an infection.

In another instance, the doctor described—in turn—the patient's "florid mania," "psycho-motor agitation," "grandiose delusions," "accelerated and pressured speech," "non-linear thinking," "increased sexual interest," and "disinhibition," only to spend much of his testimony on the patient's single "dangerous" act: destroying a paper towel dispenser.

Hearings for retention and release frequently happened at the same time as hearings for involuntary medication. The two were tightly linked insofar as a choice not to take medication was what made patients dangerous. To get approval for a "treatment over objection" order, psychiatrists also had to testify as to whether patients had a "capacity" to make a "reasoned decision" about medication (*Rivers v. Katz* (495 N.E.2d 337 [1986])). To the frustration of MHLS lawyers, however, most cases defined "capacity" tautologically: patients who agreed to take medication showed they had "capacity" to make "reasoned decisions"; those who refused did not. These hearings on involuntary medication required psychiatrists to testify of the "costs" and "benefits" of medication.

The benefit was frequently articulated as "being able to be discharged," not an improvement in well-being, and the cost of non-compliance "remaining in the hospital."

Implicit in their testimony, paradoxically, was the presumption that all patients actually did have the capacity to make a reasoned decision to accept medication, precisely because they could calculate that it would lead them to discharge. This was visible when it was the patient's turn to testify, and the hearing often took the form of bargaining over what constituted "compliance" and what patients would get in exchange for it:

> *Patient's Attorney* [to Psychiatrist]: There's no guarantee he'll get better with meds, isn't that true?
>
> *Psychiatrist*: Well it's…
>
> *Judge* [cutting off Psychiatrist]: Of course not! [To Patient] Listen, do you want to go home?
>
> *Patient*: Yes, but those things [medications] are poison!
>
> *Judge*: If you want to go home, you have to take meds. [To Psychiatrist] How long until his mood stabilizer reaches a therapeutic level?
>
> *Psychiatrist*: Usually about a week, but we like to keep them to observe…
>
> *Judge*: Okay, I'm ordering the meds, but you only get to keep him for one week if he takes them.

In counseling their clients, one MHLS lawyer told me, "We have no role in helping them gain 'insight'"—that is, an awareness of their illness—"but we can tell them that the hospital is looking for medication compliance and behavioral control." Questions designed to show patients' willingness to take medication nearly always elided the question of whether they actually identified as mentally ill.

In short, lawyers, judges, and psychiatrists together searched for short-term compliance with medication, the benefit of which was greater freedom from psychiatry, rather than the more positive, long-term relationship with it encouraged in France. In fact, psychiatrists expected no follow up care for many patients:

> *Patient's Attorney*: What is your plan for Mr. [X]?
>
> *Psychiatrist*: Medicate her and discharge. We need maybe two or three days for it to kick in, one day to observe.
>
> *Patient's Attorney*: And she has a place to go?
>
> *Psychiatrist*: I honestly don't know. Maybe a homeless shelter.
>
> *Patient's Attorney*: And you'd discharge her anyway?
>
> *Psychiatrist*: Yes.

According to the testimony I heard from psychiatrists, nearly a third of patients were to be discharged to homeless shelters. MHLS lawyers frequently argued that a history of navigating the shelter situation was a sign of patients' ability to survive autonomously. In a mental health system where hospital beds have been cut to the extent that, to quote one psychiatrist, "everyone is an inappropriate admission" (qtd. in Rhodes 1991:41), the fabrication that all patients were theoretically capable of making reasoned decisions was a necessary one for the work of both psychiatrists and lawyers.

Some patients left under the aegis of "Assisted Outpatient Treatment," a program that allows patients (or prisoners) to be discharged with a court order requiring them to take medication, go regularly to a clinic, or submit to drug testing. AoT has provoked virulent debate in part because, by allowing county health departments to instruct sheriff's deputies to pick up a non-compliant patient and bring them to an ER for evaluation, it seems to offer the possibility of indefinite psychiatric coercion (see Gong 2017). Yet doctors, patients, and judges all knew that AoT was actually "toothless," because only twelve percent of non-compliant patients subject to "removal" from the community would actually be admitted to the hospital.[31]

As such, a patient adamantly refusing AoT was not an appropriate candidate for this modality of involuntary treatment. Instead, an AoT-appropriate patient was someone who continued to lack "insight" into his or her condition but was savvy enough to see AoT as a way to advance to a lower level of coercion. At one AoT hearing for a long-term patient at a state hospital, the MHLS attorney informed the judge, "My client is objecting to the AoT order." The judge responded, "Have you explained to your client that if he prevails, he's likely to stay in the hospital for a long time? Why don't you confer with him to make sure he wants to object." The judge then elaborated, "If he's loathe to comply, then I'm reluctant to sign…AoT requires a certain kind of compliance." He then turned and addressed the patient directly:

> I want you to look inside yourself. If you leave the hospital, you need AoT…But I have doubts about your compliance. I need to see that you have some skin in the game. If not, I'm not going to sign, and that means that you're going to stay for… whatever.

His threat was largely empty—the hospital would certainly not keep him for "whatever"—but what lawyers called the "black robe effect" worked. The patient conferred with his attorney, who then announced, "He's no longer opposing the AoT order." The judge signed it and declared, "Congratulations!"

If judges in New York also encouraged patients to agree to psychiatric care that would remain involuntary, the kind of compliance the court wanted was narrower than the consent sought in Paris. As the hospital lawyer confirmed with one psychiatrist, "She's just agreeing to AoT because she wants to get out of the hospital, not because she accepts her diagnosis?" "Yes, that's correct." Again, the expectation was, paradoxically, that patients were capable of making logical decisions. Explained one MHLS lawyer, "People want to stay out of the hospital. This [AoT] gives them an incentive to take their meds. No one ever says, 'you know, I'd prefer to be in a psychiatric hospital,' even if they're living in a homeless shelter." Public psychiatry was presumed to be something patients would invariably want to avoid to the maximum extent possible.

In short, hearings became a space in which negotiation brought divergent interests—that of the hospital and psychiatrists in gaining compliance while conserving limited treatment resources, that of the lawyers and judges in showing respect for patients' rights, and that of recalcitrant patient in partly escaping psychiatry's grip—into alignment.

Conclusion: Serviceable Objects

This chapter joins a growing body of research that shows the tightening imbrication of medical and legal institutions in governing poor and marginal populations (Lara-Millán 2014; Levitsky 2013; Seim 2017). The separation between the populations these institutions both care for and control has blurred, as medical conditions are criminalized and criminality is treated medically (Bosk 2013; Hoppe 2014; Stuart 2014). On the surface, hearings on involuntary commitments show the clashes that can take place at this intersection of medicine and law. Lawyers seek to valorize their clients' rights as legal subjects, while psychiatrists and representatives of the hospitals seek validation that their patients merit involuntary treatment.

By looking at these hearings in a comparative perspective and in their larger legal environment, I am able to show how these hearings reflect much broader tensions around the meaning and priorities of rights, psychiatric care, social protection, and cost controls in mental

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[31] Office of Mental Health. "Program Statistics: Removals Resulting in Hospitalization." Retrieved June 3, 2019 (https://my.omh.ny.gov/).

health systems. Drawing on a body of comparative literature, my research points to the different cultural "repertoires" available to state actors in responding to these challenges (Christin 2018; Dobbin 1994; Fourcade 2009; Lamont and Moody 2000). Certain practices theoretically available to professionals—a lawyer trying to convince a patient to identify as mentally ill in the U.S., or a judge calling into question a medical diagnosis in France—nonetheless appeared unthinkable. I argue that the centerpiece of this repertoire is a particular understanding of what it means to be mentally ill, why it is problematic, and what should be done about it. The concept of "serviceable object" (Goffman 1961:379) is intended to capture the ways these conceptions tend to hang together, creating a common logic to bureaucratic, medical, and legal interventions.

Through interviews and historical analysis, I have shown how this vision of serviceable objects, if renegotiated at the margins in the courtroom, is nonetheless systematically embedded in the functioning of law within mental health systems. Indeed, this approach helps make sense of enduring differences between the two countries. While both might be converging on a bio-medical understanding of mental *illness*, I show how the vision of the mentally *ill* as persons diverged. In the U.S., the now-dominant "recovery" model of treatment assumes that, in the name of patient autonomy, consumers should "live with the consequences of their choices" (Jacobson and Greenley 2001:483). In this respect, the objects of these hearings in New York were already well on the road to recovery, as they were being confronted with the consequences of their decision to (not) take pharmaceutical treatment. Many informants in France doubted that "recovery" could even be translated into French; even if it were, though, an active shifting of responsibility onto patients would go against the passive citizenship that lawyers, judges, and doctors thought made a patient "serviceable".

These drastic differences in "serviceable objects" between the two countries are belied by the fact that both the French and U.S. polity have long claimed to be organized around visions of the "universal subject" that embodies common human aspirations to "modernity, progress, rationality, liberty, democracy, human rights, and equality" (Lamont and Moody 2000:3; see, also, Brubaker 1990). This chapter, however, raises the idea of a less-universal object—that is, the particular type of person on which the state can act at all. If, as Durkheim (2014:309) argued, the "one rule of conduct whose moral character is undisputed" is "that which decrees that we should realize in ourselves the essential features of the collective type," it is easy to see why the severely mentally disordered appear so disruptive. State agents in the two countries acted based on a seeming moral obligation to restore the mentally ill to a kind of object on which the "collective type" can be imposed. Yet, ironically, each country's vision of the ideal subject is, to some extent, already assumed for mentally ill objects. Mentally ill persons in the U.S. are expected to behave rationally even as they have been deemed medically incapable of doing so. In France, they are presumed to subconsciously want solidarity that they have already rejected.

Examining the mental health system in an era where medicine was unchecked by law, Goffman (1961:133) described the ritualized degradation by which a new admit to the asylum "starts out with relationships and rights" and "ends up…with hardly any of either." Today, "rights" clearly weigh into the balancing act between social control, care, and costs. Courts that rule in favor of patients around 10% of the time constitute a real check on psychiatric power. Yet, fifty years after both countries symbolically abandoned an asylum model that deliberately distanced mental patients from their normal social ties in favor of keeping them in the "community," the "relationships" these hearings produced and protected were, above all, those with the prescriptions and personnel of the mental health system itself

Conclusion: The Dignity of Madmen

When Foucault (1981:409) decried psychiatry as a "medical discipline conceived of as a reaction to the dangers inherent in the social body," he may very well have had in mind the Psychiatric Infirmary of the Parisian Prefecture (*Infirmerie psychiatrique de la préfecture de police,* or IPPP) of Paris, just a few metro stops from the Collège de France. For two centuries, the IPPP has been the obligatory passage point for individuals picked up by the police who are on their way to an involuntary hospitalization for "troubling the public order" and "risking the safety of persons." It is a symbol of a regime of exception that prevails in the Capital. Subsequent to the transfer of medical care in prisons to the Ministry of Health in 1994, it is the only nominally "medical" structure left still managed directly by the Ministry of the Interior. This "unbelievable mixing of medicine and control," as one lawyer described it to me (Interview, 8/22/16) is one in which, another lawyer perceived, an "all-powerful medicine…exists to validate a privation of liberty" demanded by the state (Interview, 7/8/16). It was already decried by government inspectors in a 1973 report on the future of psychiatry as something that "cannot be tolerated much longer," a sentiment echoed consistently in decades thereafter.[1]

The IPPP is really just one floor of a non-descript administrative building belonging to the prefecture. It incarcerates—or cares for?—patients—or is it inmates?—in conditions that are, at best, spartan. Those held there remain in rooms with virtually nothing other than a mat on the floor, until, after a wait of up to twenty-four hours, they are seen by one of the IPPP psychiatrists. I was able to view a clinical presentation of one case at the IPPP's weekly seminar. The psychiatrist opened his description of a forty-seven-year-old man of North African descent:

> This is an individual who was picked up by the police for aggression and attempted theft with 'inadapted behavior.' When he came in, his contact with us was superficial, but there was no frank disassociative symptomology or obvious decompensation. The intern who saw him first noted that he has a different comportment with men and women; he moves from aggressive and threatening to more seductive. We did toxicology tests, and they came back positive for marijuana but negative for cocaine. He had a hospitalization in 2005 and one ER visit in 2014, which led to a single consultation at a CMP. Other than that, we know very little about his history.

The man is brought in by two security guards and a nurse. The psychiatrist sits behind a desk, old copies of the journal *Annales Médico-Psychologiques* going back to 1843 in a glass case behind him. Before the psychiatrist can start, the man demands:

> *Patient*: What is this place? It's like a prison.
> *Psychiatrist*: Monsieur…
> *Patient:* Are you going to even offer me a coffee?
> *Psychiatrist:* After our interview. Do you know why you are here?
> *Patient:* I don't understand anything. Who are these people behind me? It seems like they're trying to… get into my head.
> *Psychiatrist:* We're here because we need to decide whether you need psychiatric care.

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[1] Inspection générale des affaires sociales. 1973. *La prévention des maladies mentales. Rapport annuel 1973 sur le thème de la prévention.* Paris, France: 809. This same point was made in three reports in the late '90s and early 2000s, some of which had no obvious reason to raise the topic. Strohl, Hélène and Martine Clemente. 1997. *Rapport du groupe national d'évaluation de la loi du 27 juin 1990*. n°97081. Paris, France: Inspection générale des affaires sociales; Piel and Roelandt, *De la psychiatrie vers la santé mentale*; Charzat, Michel. 2002. *Pour mieux identifier les difficultés des personnes en situation de handicap du fait de troubles psychiques et les moyens d'améliorer leur vie et celle de leurs proches.* Paris, France: Ministère de la Famille, a l'Enfance et aux personnes Handicapées.

The psychiatrist probed him about his immigration and work history, a trajectory that led him to a current state of precarity and subsistence off of France's minimum government income. The man resisted giving any details about the context of his arrest:

> *Psychiatrist:* Monsieur*,* I need to know, how can we help you?
>
> *Patient:* You can let me go!
>
> *Psychiatrist:* If you leave, you're going to go back to custody.
>
> *Patient:* You are judging me! Like I'm a *malade*, a criminal. Who are you? Are you a doctor? A singer?
>
> *Psychiatrist:* Do you believe that people can send you messages through their thoughts?

The man, looking increasing agitated, started speaking rapidly in Arabic. At this point, the psychiatrist delivered his medical assessment (or was it a verdict?):

> *Psychiatrist:* I am going to hospitalize you. I'm afraid, given your reticence to acknowledge your problems, that if we let you go, you're going to reproduce the same situation over again. For someone like you, a psychiatric unit is better than jail.
>
> *Patient:* I don't know what you're talking about. I'm normal, I live a normal life.
>
> *Psychiatrist:* You are going to be hospitalized, you are in 'imminent peril.'[2]

The patient went silent. At the end of the presentation, the psychiatrist explained, "This was not an easy decision. You could see there was excitation and hyper-vigilance, very very persecuted, but no clear delirium. It's hard to show he's dangerous, but he needs care. I think on some level he knew that, which is why he didn't resist the hospitalization more." I asked the psychiatrist how he ascertained this submerged desire for care, and he told me, "You Anglo-Saxons aren't accustomed to really reading anything into psychotic symptoms. We are" (Fieldnotes, 5/13/16).

The patient's confusion about where he was is understandable. In 2015, the General Controller of Places of Deprivation of Liberty observed that the IPPP had "nothing to do with a proper hospital designed to *accueillir* [receive or welcome] *malades mentaux*," noting that neither the rights of people in a hospital nor those in a regular prison apply there.[3] The IPPP is only marginally a place of medical care, in part because some of the doctors believed that aggressive treatment might cover up the symptoms they needed to identify and interpret. Rather, the IPPP is a place of sorting. When Jacques Lacan did his internship in the IPPP in the 1930s, the place was one where the "cult of the gaze" obsessed with the correct classification of mental illness "was pressed to a paroxysmal extreme" (Roudinesco 1990:105). This gaze fixes on those otherwise left out of the health system, as the old head of the IPPP explained: "Some want to do a psychiatry…that cares for the depressed, the neurotic, the soft and deficient psychotics…clean and *santé-mentaliste*…[But the IPPP is for] those outside of the *secteurs,* the undesirables, hopeless, in decompensation, bare feet and smelling of alcohol" (Feillard 2005:18). But, in contrast to how Foucault might see it, the doctors who worked at the IPPP also saw themselves as avoiding the medicalization of deviance and social disorder. As one explained, "We are a filter, that helps identify that people who are *malades mentaux* and who need care…and that avoids the hospitalization of the rest" (Interview, 7/11/16). In fact, in other clinical presentations, these doctors focused on how to identify people who were malingering to get out of jail or who were just high on drugs and who needed to be kept out of the psychiatric system entirely. They were, as so many professionals in the French system, perpetually searching for the real *malades.*

Just about everything about the IPPP—from the poor physical conditions, to the utter lack of standardization of practices between doctors (who ranged from moonlighting psychoanalysts

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[2] His reference was to a modality of hospitalization, *soins psychiatriques en cas de péril imminent,* that allows a psychiatrist to hospitalize someone in the absence of a third-party demand (either from a family member ["*tiers*"] or the prefecture).

[3] Contrôleur général des lieux de privation de liberté. 2015. *Rapport d'activité.* Paris, France: Dalloz: 61.

who usually exercised in the private sector to university neuro-biologists), to the patients' nearly non-existent access to legal representations—would horrify my American informants. But some elements of the way professionals at my U.S. field sites understood and responded to those real *malades* would offend those at the IPPP in more subtle ways. In the California clinic, the head of the Intensive Case Management team spoke of one of these homeless "undesirables":

> *ICM Director:* We're thinking of bumping him up to a higher level. He keeps calling us high on meth asking to change providers.
>
> *Case Manager:* Basically, he just wants housing.
>
> *ICM Director:* Honestly, he barely belongs here. He's more anti-social than anything.
>
> *Psychiatrist:* There might be an underlying thought disorder, but it's hard to know because he's always on drugs. He's definitely violent.
>
> *Clinic Director:* When he's off, he's really scary.
>
> *MCT Director:* I hate to go all 'shrink' on you, but do we think there's a reason he's so aggrieved?

The comment provoked a round of laughter (Fieldnotes, 3/15/18). One clinician, though, spoke with frustration that "go[ing] all shrink" had become an action discouraged by regulators and the system's leadership:

> About three years ago, the system changed its name from 'community mental health' to 'community behavioral health.' This is a major change. If somebody comes in and says, 'I was so depressed, now I'm feeling so much better, the meds are working, I'm optimistic,' you can't write that any more. You have to show that improvement results in behaviors. So, you call something mental health, you give credence to the mind of the person and their subjectivity. When you have behavioral health, who cares [about that]? (Interview, 3/19/19).

When I mentioned to a French *secteur* psychiatrist the idea that we might relabel "*santé mentale*" [mental health] as "*santé comportementale*" [behavioral health], he just laughed. What could be more superficial and American?

A pathway through the IPPP offers a host of indignities. But it offers one dignity increasingly abandoned in the behavioral health system in the U.S.: the dignity of being mentally ill at all. The IPPP has value if you believe that it actually matters whether people receive treatment in prison versus in a hospital, on the basis of a social statute of "inmate" versus "patient." Holding someone for observation and holding off on heavily medicating them makes sense if you think that there is something to be gained from knowing if a person's suffering stems primarily from pathology, from precarity, or from personality.

This dissertation has argued that understanding how states match people and problems with the institutions designed to respond to them is crucial for piecing together the fragmented trajectories of the mentally ill in post de-institutionalization mental health systems. It suggests that the contrast between the IPPP and the California clinic, less in terms of how they diagnose and treat illness and more in terms of how they classify and orient people, deserves more sociological attention. In this conclusion, I reflect on the dissertation's implications for the literature on states, national cultures, and the production of the self, before asking (if only partly answering) the key question anyone reading a comparative study of welfare systems should want answered: "which system is better?"

States and Social Policy

This dissertation uses the case of severe mental disorders to understand how states classify, construct, and govern their citizens. I set myself to either reconcile or adjudicate between two contradictory observations in the literature. The first is that states are powerful in their capacity to impose "categories of thought, of perception, of construction of reality" as well as "agreement on a certain number of values" on their citizens (Bourdieu 2015:4). Research has shown how official classification schemes flow from the upper echelons of the state to lower-level state agents and ultimately into the population, drawing on case studies of the categorization of race (Loveman 2014; Mora 2014), sexuality (Canaday 2009), and criminality (Norton 2014). The second claim in the literature is that, paradoxically, these coherent classification schemes are supposed to come from an entity that is, itself, essentially fragmented and incoherent. Research is "mov[ing] away from conceptions of states as unitary actors and toward an understanding of states as encompassing multiple institutions, varying forms of interpenetration with civil society, multiple scales of governance, and multiple and potentially contradictory logics" (Morgan and Orloff 2017:3).

This latter perspective makes more sense in light of the frameworks that have typically served in the analysis of mental health systems. First, public mental health systems are operated by competing professional groups vying for jurisdiction (Abbott 1988; Goldstein 1987; Mechanic et al. 2014). Second, the severely mentally disordered depend on services provided by a multitude of medical, judicial, and social agencies. Each, the literature on street-level bureaucracies suggests, has every incentive to conserve its scarce resources and push recalcitrant and refractory clients onto others (Lara-Millán 2014; Seim 2017). Finally, the mental health system is riven with competing approaches to the appropriate goals of treatment and visions of the people they serve, furthering this fragmentation (Dobransky 2014; Hasenfeld 1985; Scheid 2004).

The between and within-country comparative approach of this dissertation allows me to evaluate these two perspectives. Particularly in cases like the "mental illness merry-go-round" in California described in Chapter 3, I identify practices of "burden-shifting," uncertain jurisdictions, and incoherent policy direction. These point to the accuracy of depictions of the state as a "set of conflicting institutional contexts" (Haney 1996:760) or "assemblages…of many and often conflicting people and objects (Joyce and Mukerji 2017:1). Chapter 2, on the introduction of "psychic handicap" in France, similarly shows how even a policy initiative with the apparent full weight of the state and civil society behind it can flounder as it collides with the ground-level practices of state agencies marching to the beat of their own organizational drummer.

At the same time, though, I find patterns in classificatory practices in different institutions dominated by different professional groups within each country, and divergence between similar professional groups (like psychiatrists) between them. The functioning of the French and American states appears consistent with Norton's (2014:1572) reconceptualization of the state as "a network of actors connected by their orientation to a more or less common system of meaning, revealed through more or less coherently organized patterns through the identities and relations of state meaning structures are enacted in the world, and thus become real." The three parts of this dissertation identify different ways in which classification by the state is patterned.

First, in Chapter 1 in particular, I show how state actors in each country draw from a common "national repertoire" of classification. With respect to mental illness, professionals and bureaucrats in each country seem to draw on a common reservoir of types of categories, modes of carrying out classifications, conceptualizations of the objects of classification, and concerns about the potential risks and tensions in placing people into administrative boxes. The common use of "real *malades*" by psychiatrists in the Clinic, social workers and psychologists in the Disability Office, and judges in commitment hearings is particularly visible in France. But a mutual conception of "mental illness" as existing on the same continuum as "mental health" and as not mutually exclusive with but intimately linked to criminal behavior and drug use was also relatively universal in the U.S. Perhaps, as the example of the IPPP above suggests, the two countries also differ in the power they attribute to the act of classification at all. The French showed a concern with how labeling people "*malade*" would make them into one. For my American informants, classification was more purely descriptive rather than productive. Ironically, in the home of the DSM, diagnosis was often a throw-away label to meet minimum administrative requirements, rather than itself a productive category.

The second part of this dissertation, focusing on access to social services through the category of "psychic handicap" / "grave disability" shows another patterning of state action through the elaboration, application, and institutionalization of "state kinds." Following Hacking (1995)'s idea of "human kinds," I understand "state kinds" as packages of knowledge, practices, and moral evaluations about groups of people which are applied to concrete individuals. These chapters build on arguments in the literature on street-level bureaucrats that bureaucratic classification is a form of "symbolic violence" (Dubois 2003:66) through the brute simplification of human complexity:

> People come to street-level bureaucracies as unique individuals with different life experiences, personalities, and current circumstances. In their encounters with bureaucracies they are transformed into clients, identifiably located in a very small number of categories, treated as if, and treating themselves as if, they fit standardized definitions of units consigned to specific bureaucratic slots (Lipsky 2010:59).

Understanding state interventions as organized around distinct "state kinds" helps make sense of the conflicts and contradictions that emerged in Chapters 2 and 3. In France, "psychic handicap" was what I call a "bureaucratically split personality" because the state kinds of "disabled person" and "*malade mental*" were mutually exclusive. On the other hand, in the U.S., potentially conserved individuals wound up bereft of any bureaucratic identity at all. The reality of state agencies designed to serve a single state kind clashed with both a political expectation that they serve multiple. Bureaucratic "state kinds" overcame an abstract awareness that severely disordered people had overlapping challenges that could not be addressed separately.

Chapter 4 observes that scholarship on welfare states has often focused on the ultimate divisions around which social policy is designed, such as "deservingness" in the U.S. or "solidarity" in France. The mentally disordered are a strategic case, however, for examining how welfare states also rest on distinctive foundations of what makes a person "serviceable" to state institutions in the first place. In both France and the U.S., the goals of the mental health system are increasingly defined at a high level in terms of "recovery," "autonomy," or "empowerment." But in civil commitment hearings, we can see how professionals grapple with a more basic challenge: making individuals into persons for whom there is a clear repartition of jurisdiction for intervention, into whose lives they can intervene with a minimal amount of legitimacy, and from whom they can extract a modicum of cooperation. What emerges is that similar individuals are problematic for different reasons in the two countries. In France, the most severely disordered are knotty because they reject services which are supposed to be universally accessible and high quality. They thus refuse what should be an identity honored by the welfare state: "suffering citizens." In the U.S., they lack the residual rationality of "compliant calculators," which would allow them to navigate a residual welfare state.

My hope is that this dissertation does more than just offer another push of the pendulum between a materialist view of states as "weighty actors" (Skocpol 1985:3) and a cultural turn that sees them as fragmented and "elusive" (Mitchell 1999:77). I have sought to follow Morgan and Orloff's (2017:3) admonition to "both disaggregate and reaggregate, being attentive to the variable and shifting components of states without losing sight of that which binds them together." Mental illness is a useful case because it represents an arena where official policy has been long seen as ineffectual or contradictory and where bureaucratic and professional conflict is rife. But I find that there is a "fundamental consensus on the meaning of the social world" that becomes the "very precondition of conflict over the social world" (Bourdieu 2015:4). Looking historically and comparatively, we can identify an infrastructure of shared categories and conceptions that help give the management of populations continuity and coherence.

National Cultures and the Self

In the face of so many centrifugal forces, what is it that makes state responses to severe mental illness nonetheless hang together in this way? My findings *describe* common practices of classification and conceptualizations of mental illness but do not get directly at *how* such disparate groups of professionals come to see things in similar ways. Implicitly, each chapter of this dissertation has rested on the notion of some common *habitus* among state agents, or a set of deeply-ingrained "categories of thought" and principles for applying them that we "spontaneously apply to all things of the social world—including the state itself" (Bourdieu 1994:1). For state agents, this *habitus* "step[s] in to fill the gaps in the regulations" (Bourdieu 2005:130) when official policy itself is unclear. I asked the director of a hospital in France how they were supposed to respond to rising demands with limited budgets: "We have no directive. It's just 'figure it out'" (Interview 7/1/16). Yet across France, *secteurs* seemed to figure it out the same way: "the *secteur* is for those with the heaviest psychiatric pathologies, principally psychotics" (Interview, 8/12/16) plus, another told me, "those who really want it" (Interview, 7/26/16). This combination of criteria was almost never deployed in the U.S.

The notion of a *habitus* reminds us that, underneath the diagnostic categories or benefit criteria that doctors or bureaucrats learn in medical school or professional training, there are more fundamental classifications of the social world that they are socialized to use much earlier. Given that states claim a "priority…over the legitimate means of socialization within a given territory" (Gorski 2003:xvi), it is not surprising that there would be a close correspondence between the divisions of the social world embodied in the state and those embodied in the people who grow up to be state agents. Every time someone in the U.S. fills in a form asking for our "race," we learn that this is a meaningful category, an experience the French state has studiously tried to avoid. The more formal classifications (like diagnoses) that have attracted so much sociological attention are layered on top of divisions that constrain their use. Various substance use disorders might make their way into to DSM, but French professionals' use of them was inhibited by a more basic conception of addiction and mental illness as separate.

The idea that "different societies create different types of individuals" (Fourcade 2009:14) has been affirmed in the study of mental health through ethnographic examinations of the differing subjectivities of the mentally ill (see, e.g., Jenkins 2015; Watters 2011). This dissertation, however, extends this insight to the people treating them, suggesting that care for the severely mental disordered depends on the socially-specific subjectivities of the psychiatrists, social workers, or judges assigned to deliver it. The concept of "national cultures"—a stable set of norms and values more-or-less adhered to across a national territory—has fallen out of fashion in sociology. We instead increasing think of culture as something "fragmented across groups and inconsistent across its manifestations" (DiMaggio 1997:264), made up of "diverse, often conflicting, symbols, rituals, stories, and guides to action" (Swidler 1986:277). Culture is best seen at the level of situations, not societies. Yet without something akin to culture shared at a national scale it is difficult to make sense of differences that seem so systematic between two countries and the surprising points of convergence within them. From a material point of view that counts the number of beds or psychiatrists, New York is closer to France than to California—but those ample beds and psychiatrists are used in ways that are distinctly American.

Although I do not directly examine the lived experience of people with severe mental disorders, I still see this study as helping to illuminate a key piece of any culture: the expectation that it places on the self. Elias (2000:378) claimed that the "social molding" of the individual in the West demanded an "intense and stable regulation of drives and affects." Only "perhaps in the case of madmen" could we see "psychological functions in their pristine state, in a state of nature that is not patterned by social learning" (Elias 2000:409). Although he missed the extent to which even "symptoms" are culturally determined, he correctly pointed to how severe mental disorders push upon the "outer reaches of your space as an individual" (Hacking 1999:167–68). Studying how mental health systems push back shows more clearly where those outer reaches lie. What emerges is that, despite a common Western ideal of the self as "individualized, bounded, with interior depth and temporal continuity, self-possessed, autonomous, free to choose" (Rose and Abi-Rached 2013:203), which violations of these ideals provoke the most corrective efforts varies. American professionals, for example, were likely to accept selves that seemed to have little depth or history, but were concerned with someone's ability to make good choices. More quantitatively, even if mental health clinicians were more forgiving towards their clients than the unemployment counselors studied by Sharone (2013), this study illuminates the heavier expectations of American culture which may both justify and drive a push to expand mental health treatment.

The ethnographic approach of this study allows me to share with other cultural sociologists the shift from seeing culture in terms of dis-embodied values to "micro-practices" that "reproduce the structure of the whole from the ground up" (Biernacki 1995:203). When I asked my interviewees what the goals of mental health treatment should be, I received sufficiently disparate answers as to call into question the idea that there was really any American consensus around "rights" or "autonomy" or French focus on "community integration" (Figure C.1). But the way professionals actually acted *did* suggest that these concepts provided an underlying motivation for action. Even as ethnographers are admonished to focus on the local, the situational, and the relational (Desmond 2014; Jerolmack and Khan 2014), they may also be uniquely positioned to identify these cultural forces.

This dissertation is thus further evidence that "cultural specificity survives with astonishing resilience in the face of the leveling forces of modernity" (Jasanoff 2004:14). Perhaps there is nothing surprising that Americans would fixate on practical self-governance and the French, ever interested in "theory" (Payer 1988), would want to know where illness comes from and care about whether it addressed root causes and not just surface manifestations. Ultimately, I fall back on the idea that documenting and explaining the persistence of these differences, predictable though they might be, has scholarly value in its own right. Much as with states, after we have pulled apart culture and turned into an ad-hoc "toolkit" navigating through a sparse cultural "scaffolding" (Lizardo and Strand 2010), there is some re-aggregating to be done to explain how it nonetheless manages to have weighty effects.

Citizen-Patients

"So which system is better?" It's the most obvious question to ask of any comparative study and also among the most difficult to answer. This dissertation has hopefully been persuasive in insisting that the boundaries of any seemingly natural diagnostic category—even one with at least some firm biological and genetic basis, like schizophrenia—are fluid over time.[4] The concrete living persons placed within even common categories vary between countries. Even if we could match "the mentally ill" or "people with schizophrenia" across national borders, answering the question requires some consensus of what outcomes would go into an evaluation of "better" or "worse." The professionals I interviewed—who varied from seeing themselves as "promoting empowerment" to "soothing suffering"—evinced little such agreement (Figure C.1).

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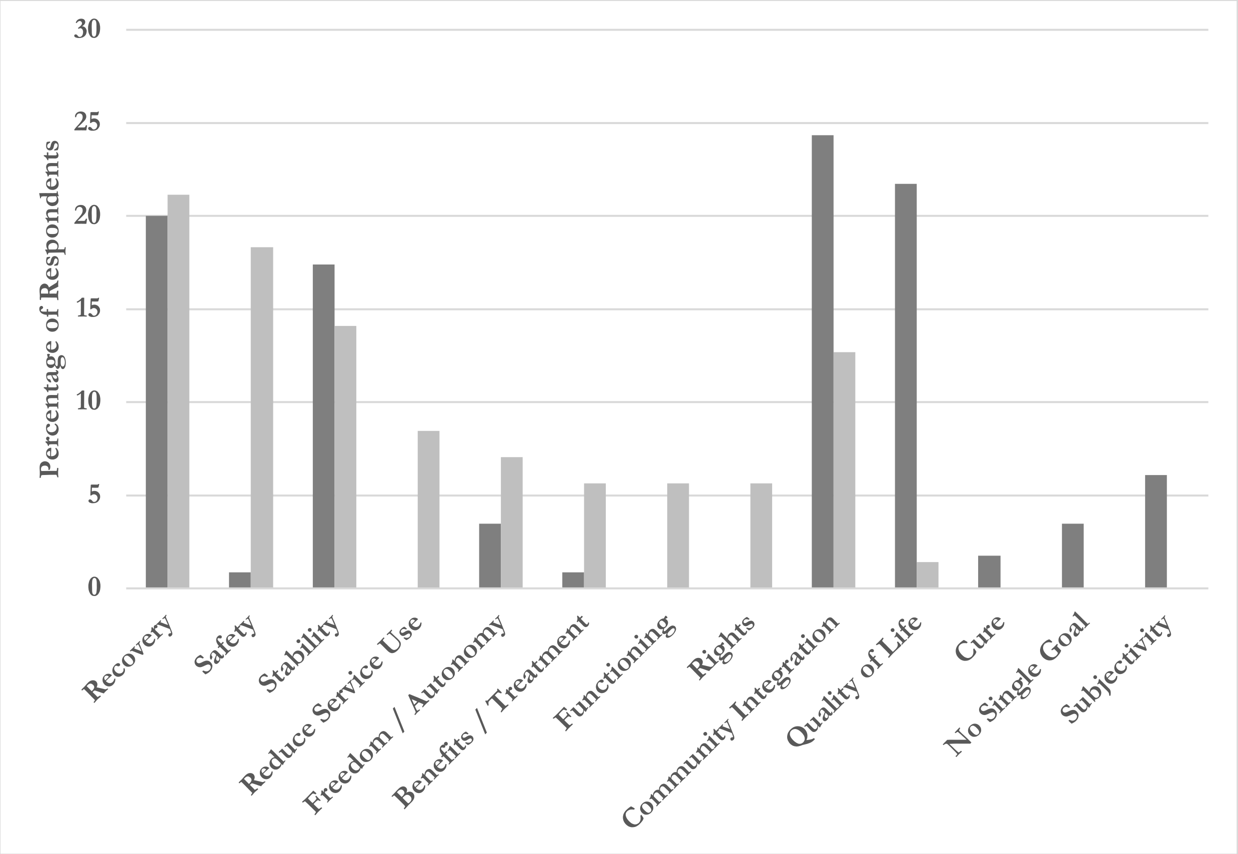
[4] The most persuasive example of this I have ever seen is from Metzl (2009), who shows how diagnoses of "schizophrenic reaction" in white housewives who "got confused" and "embarrassed husband" were crossed out and replaced with "depressive neurosis" in state hospital dossiers in the 1950s, at the same time as black men's "psychopathic personalities" became "schizophrenia, paranoid type."

Figure C.1: Goals of Intervention in France and the U.S.



Source: Based on 115 interview respondents in France and 71 in the U.S.

One way to dodge the discord about how to measure whether mental health systems improve the lives of the severely mentally disordered is to ask, rather, the degree to which they let them die. In France, the average age of death of a person with schizophrenia is as an astonishingly low 59.8 years (Ha, Decool, and Chee 2017). For the U.S., calculating backwards from data from the National Institute of Mental Health, that figure is around 50.[5] If, as Didier Fassin (2009:53) argues, "statistics about life expectancy, as disincarnated as they may seem, tell us about how much life is worth," the life of someone with schizophrenia is worth about 20% more in France than the United States. This is not so far from the difference in the proportion of health spending consecrated to mental health in the two countries (see Figure 1.1).

But what kind of life? What does ten years of life mean if it is circulating, as the real *malades* of France largely do, between decaying public hospitals, paternalist sheltered workshops, and isolated units of public housing? Facing schizophrenia but offered my choice of services, I would take a Californian Full-Service Partnership that spoke of "empowerment" and "recovery," New York's Early Intervention into Psychosis OnTrack program focused on reintegration into the "ordinary" milieu of school and work, and the Federal Government's mandate that the system offer me support through the wisdom of peers and a respect for "consumer" choice.

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[5] NIMH states that people with schizophrenia live 28.5 years fewer than those without; U.S. life expectancy is currently slightly above 78 years. National Institute of Mental Health. "Schizophrenia." Retrieved May 17, 2019 (https://www.nimh.nih.gov/health/statistics/schizophrenia.shtml).

But what if I were not offered that choice—because, when it comes to social welfare systems, who really is? If I were behind a Rawlsian veil of ignorance, certain only that I would have schizophrenia but not whether I would wind up in the upper-echelon of innovative services, I would choose France. Asked one discontented French psychiatrist, "Should we really be celebrating the equation: reinserted *malade mental* = anti-psychotic injection + disability income + legal guardian?" (Martin 2000:9). My answer is an equivocal "yes." As I waited for the transformative "further breakthroughs…[that] are likely to depend on discoveries in genetics and neuroscience" (Collins et al. 2011:30), for which we have been waiting now for decades, I would want housing, a standing appointment with a *secteur* psychiatrist, and a hospital stay when I needed it.

The recurrent aspiration is always that you could have both the baseline of quality services of France and the dynamism of the United States. I am skeptical. France is building the American-style accoutrements of Clubhouses and ACT Teams and Housing First programs on top of a foundation of the system, the *secteur*, which is faltering. These two processes are linked. In the U.S., constant innovation rests on perennial crisis and persistent under-funding which drives a kind of implicitly desperate but outwardly hopeful entrepreneurship. I am doubtful that either country is likely to fund both models—one of acute treatment oriented towards recovery, the other of chronic care that provides protection—simultaneously. As the swing back towards locked, long-term facilities documented in Chapter 3 on California suggests, the two systems may be swinging towards one another, based on a growing desire for the very thing the other system is abandoning.

But isn't this a false choice created only through the stinginess of policymakers who are blinded—perhaps by stigma (Corrigan and Watson 2003)—to the true scale of the problem? This dissertation could presented the seemingly objective argument for more services based on the scale of mental health issues. Indeed, the most frequently cited statistics on mental illness seem to provide a ready-made motivation for any study on the topic. These conditions account for 22.9% percent of Years Lived With Disability worldwide, inching out Musculo-Skeletal disorders for first place (Whiteford et al. 2013). According to the World Economic Forum, mental health problems account for 35% of global output lost to disease, costing humanity a collective $2.5 trillion per year.[6] In truth, these statistics are driven by the expanding frontiers of "mental illness" into the realms of sadness and stress. These statistics are not a compelling argument for taking better care of people with schizophrenia because they are few and their potential productivity low. And because the disorder begins in adulthood, its sufferers are likely never to evoke the sympathy and resources given for autism or developmental disabilities.

Social scientists' themselves make pleas for greater attention to madness that are not just actuarial. Those of us committed to the study of the topic like to imagine, as Scull (2015:10) argues, that "madness in indelibly part of civilization…It is a problem that insistently invades our consciousness and our daily lives." It "cannot be ignored" as it "threaten[s], both symbolically and practically, the very foundations of social order" (Scull 2015:24). I would, in an odd way, love that madness be so striking that we cannot look away. But both the sweep of history and contemporary policy suggest that societies have proven quite good at limiting themselves to a minimum level of management or warehousing, or simply abandoning, the severely mentally ill. If "mental health" has become a growing topic of conversation, "mental illness"—at least, as it was narrowly defined until relatively recently—is not. Observed Hacking (1998:222) "gone are the days when the cruel show at

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[6] Bloom, David E., Elizabeth Cafiero, Eva Jané-Llopis, Shafika Abrahams-Gessel, Lakshmi Reddy Bloom, Sana Fathima, Andrea B. Feigl, Tom Gaziano, Ali Hamandi, and Mona Mowafi. 2011. *The Global Economic Burden of Non-Communicable Diseases*. Geneva, Switzerland: World Economic Forum.

Bedlam"—the famed British madhouse—"was fun." Rather, "we want to feast our eyes on the oddly dysfunctional, not on the crazed or catatonic."

The inattention to severe mental disorders in the U.S. comes, in part, through a hopelessly contradictory discourse about them. On one hand, some speak of schizophrenia as if it is "arguably the worst disease affecting mankind, even AIDS not excepted," as the Editor of Newsweek declared in 1988 (qtd. in Insel 2010:191). Andrew Solomon (2012:353), in his magisterial survey of the lives of parents of "exceptional" children, observed:

> Families rise to the occasion of various difficulties, struggle to love across those divides, and find in almost any challenge a message of hope and an occasion for growth and wisdom…Nonetheless, schizophrenia may be in a class by itself for unrewarding trauma. The rich culture of Deafness, the LPA [Little People's Association]-centered empowerment of dwarfism, the extreme sweetness of many Down syndrome children, the self-actualization of the autism rights brigade—none of this is really present in the world of schizophrenia, Mad Pride notwithstanding. We may hesitate to cure some problematic illnesses because they are also rich identities, but schizophrenia cries out almost unconditionally for treatment. The remarkable parents I met during this research would be better off, as would their children, if schizophrenia didn't exist. To me, their suffering seemed unending, and singularly fruitless.

We have, of course, made the inherent brutality of these conditions much worse through policy. In 1848, Dorothea Dix (2010:117) pleaded, "I come to place before the Legislature…the condition of the miserable, the desolate, the outcast…helpless, forgotten insane and idiotic men and women…wretched in our Prisons and more wretched in our Alms-Houses." The language may have changed, but the characterization of "outcast" and "forgotten" insane in our "prisons" and "Alms-Houses" is not so far from present reality.

And yet, at the same time, in my interviews, I often felt like contemporary discourses around mental health have left us bereft of a vocabulary to talk seriously about this suffering and the challenges conditions like schizophrenia pose. While the failure of de-institutionalization to produce self-governing, productive, autonomous citizens is now well-documented (Bagnall and Eyal 2016), only more recently have scholars begun to show how the expectation of "recovery"—meaning an ability to live a full if still symptomatic life, increasingly independently from the mental health system (Jacobson and Greenley 2001)—can create a create a stressful sense of perpetual failure among those who are supposed to fulfill these "typical North American notions of ideal citizenship" (Myers 2010:515; see, also, Padwa et al. 2016). As one soon-to-be-retired clinician in San Francisco told me:

> We want to see progress in our patients…and so you have to be in 'recovery' in some way. And I think there's a denigration of care for people who do not have the capacity to recover but can still get something out of being in community of some kind, or connecting with counselors (Interview, 3/19/19).

In the U.S., we like to talk about mental illness as an "illness like any other," but our expectations for self-direction by the severely mentally ill are very different. Observing the increasing emphasis on cheaper professionals and lay supports, one psychiatrist noted, "Absolutely, get people peers, get them case managers, but don't take expertise out of care. And that's being done. Psychiatrists are now just pharmacologists. But that's not using those resources, that expertise well" (Interview, 1/11/17). My fear is that, in putting so much emphasis on recovery, we may choose to preserve this goal by simply ignoring those individuals who do not manage to achieve it.

My informants in France were more overtly pessimistic (even if, in the privacy of our interviews, less than a quarter of American interviewees endorsed "recovery" as a goal of treatment). But they could also feel refreshingly honest, as one *secteur* psychiatrist seemed:

> Maybe with depression, you can hope for 'cure.' But for a psychotic person? We know that with psychosis, it's a combat that is often very difficult. The psychosis is often stronger than we are. We try to… The objective is that the patient is the happiest possible. That they don't hide in a cave. For a psychotic patient, we know that he could do well today, but tomorrow he could de-compensate. The objective for him, it's to not do too badly, because the mechanisms of psychosis create psychic suffering. The goal is not to be adapted to society—too normalizing—but the least suffering. The happiest possible (Interview, 8/10/16).

Another *secteur* psychiatrist who had just spent a meeting in which he triaged twenty new outpatients while simultaneously dashing off medical certificates for involuntary inpatients concurred, "I want them to suffer a little less. For some, it's just that. They may never work, never be able to live alone, to cook a plate of pasta… We need to be modest" (Interview, 5/13/16). This same language was repeated to me by the head of France's patient movement: "I don't want to be another person, but I don't want to suffer, and I don't want to make others suffer" (Interview, 5/10/16). "Recovery," noted an advocate for the families of the severely disordered, "sounds very American to us. We haven't decoded it yet" (Interview, 3/10/16).

The director of one hospital offered an interpretation that I liked, but which suggested that much had been lost in translation: "Recovery… I think that just means making it so the patients, our patients, are also citizens" (Interview, 4/26/16). Foucault and Goffman were right, in the 1960s, to assert that the "rights" of persons interned in psychiatry were being trammeled by a system of social control masquerading as one of care. Today, though, evoking abstract "human rights" that apply to the severely mentally disordered as they do to anyone else may be, as Hannah Arendt pointed out, a way of avoiding more difficult practical and material questions of citizenship for a very particular population (Dudley, Silove, and Gale 2012:72).

Perhaps, as France fights to keep its universalistic health system and the U.S. debates whether to create one, it's worth remembering that "patient-hood" is itself a form of citizenship. It can be more than just a descriptor of the receipt of medical treatment, but also a recognition of suffering and social obligation to address it. The concept of "medicalization" has a bad reputation in sociology, and nowhere more so than in mental health. But the medicalization of severe mental disorders—the idea that, as *malades,* they deserve care in dedicated institutions by dedicated professionals committed to an ethos of public service that ensures that those institutions capture the most difficult cases—is, in its own right, a tenuous cultural and political achievement.

Methodological Appendix

Schematically, the object of explanation for this study was the distribution of people with severe mental disorders between medical and social (like clinics, hospitals, supported housing, or homeless shelters). Theoretically, I view this circulation as produced from the bottom-up through professional practices of classification. My research thus focused on understanding the creation of state-sanctioned categories, regulations and practices for their use, and their uptake and application in practice. My field sites were riven with divergent perspectives and incomplete data. As one county supervisor in San Francisco commented at a hearing:

> One thing that is challenging is how disparate the perspectives are depending on where people sit. We need to sort through all these perspectives and what data we have to try to get a little bit more truth. People say all sorts of things and have all sorts of different understandings for the basis of decisions of where people get routed and… it's hard to figure out what actual truth it (Fieldnotes, 5/1/19).

I concur with sociologist Kai Erikson (1978) that at times our first duty as social scientists is to "get the story straight" using whatever methods we have on hand. In this appendix, I lay out my main data sources (ethnographic observations, qualitative interviews, primary-source documents and administrative statistics), the process of analysis and the comparative logic behind this dissertation, and this study's limitations and the boundaries of the object of analysis.

Data Sources

Ethnographic Observations

Rather than taking the population of "people with severe mental disorders" as a given, substantive group, I focused on the processes through which that group was constituted through marking its boundaries (Abbott 1995; Lamont and Molnár 2002). The population of severely mentally ill is not made in a meaningful sense through epidemiological studies showing rates of distress in the population and determining based on an arbitrary threshold what counts as "severe" and "illness." Instead, professionals, advocates, and bureaucrats create the population through a process of classifying concrete individuals as belonging to that category and by crafting institutional responses that make that category meaningful. I chose to study this process ethnographically based on two intuitions. First, that the actual categories used by professionals would differ from those emphasized in the literature (namely, diagnosis) or enumerated in policies and plans. Second, that decision-making in practice would frequently rely on a set of cognitive heuristics and short-cuts that would be missed by simply looking at the relationship between a set of characteristics articulated in a case file and a given outcome documented administratively.

Because the range of institutions that care for and control people with severe mental disorders is extensive, I had to be strategic in identifying sites that play a particularly important role in crafting the institutional trajectory of that population. Based on preliminary interviews in France, I identified the *Centre médico psychologique* [Medical-Psychological Sector] of a *secteur* as the key point of triage into the mental health system, the *Maison départementale de personnes handicapées* [Departmental Home for Handicapped Persons] as the primary gatekeeper to social and disability benefits, and reviews of involuntary hospitalizations by *Juges de la liberté et de la détention* [Judges of Liberty and Detentions] as a primary point of intrusion of the judicial system into the lives of the severe mentally disordered. There was only one MDPH and one site of JLD hearings in Paris. There are, on the other hand, dozens of CMPs in the city. I ultimately chose out one which served a district that was neither particularly affluent nor poor and which was known for being at a mid-point between French psychiatry's psychanalytic and neuro-biological poles. Like all *secteurs* in Paris, it was primarily attached to a specialized psychiatric hospital, not a general one; this is a key axis of variation between *secteurs* in France for which I have not controlled.[1]

For each field site, I targeted my observations to moments of decision-making: meetings to discuss new and difficult clients in the CMP, evaluations by the multi-disciplinary team and departmental review committee in the MDPH, and hearings by the JLDs. The basic unit of analysis was each person discussed: 260 new patients at the CMP (in addition to 79 emergency cases), 297 applicants in the MDPH, and 107 judicial controls. I also attended other staff meetings at the CMP, trainings at the MDPH, and continuing legal education courses for lawyers working on judicial controls. Around these observations, of course, I also lingered in each field site and carried out informal conversations with each set of professionals. In my time in France, I also conducted site visits to other health and housing providers, municipal mental health councils, public information events on mental health, and meetings of some activist groups.

Initially, I imagined that I would pair each of my French observations with an observation in a comparative health, social, and judicial institution in the U.S. I quickly realized that isolating institutions in this way would miss the different roles that apparently similar institutions played in each system. For example, having spent so much time in the MDPH in France, I envisioned trying to sit in on disability determinations by the Social Security Administration. But the MDPH plays a much broader role than the SSA, because it also grants access to housing and employment supports, and its decisions are supposed to be much more independent of the medical evaluations provided by the health system. Ultimately, for the U.S. I have two main ethnographic cases: a clinic in California (where I observed discussions of 78 new intakes, 80 reassignments of levels of care or closures, and 163 client status updates) and 206 judicial hearings in New York. I have no equivalent "social" ethnography for the U.S. My research on conservatorship in California (which gave access to medicalized housing in a similar if more coercive fashion than the MDPH) took place through interviews. I also attended a dozen city council hearings and working groups of the California Behavioral Health Planning Commission, as well as site visits with long-term care providers.

I have largely stepped out of the ethnographic arms race that sees many qualitative researchers spending ever more time fully immersed in the field. I did not seek to understand the "life-worlds" of professionals in each country, nor do I think I could have given the goal of understanding how classification played out across a range of institutions. I consciously chose not to observe direct interactions between providers and their clients or patients; in a field where therapy is relational, introducing a third party (especially, in France, a foreigner) could disturb a process that took priority over my own data collection. (I had less qualms about being present for judicial hearings, as there were frequently other observers beyond myself). Because I attended meetings where the individuals being discussed were not present, and those could not consent to or object to my presence, I was careful in avoiding collecting identifiable detail.

I think there was ultimately some benefit to swooping in for meetings or hearings in the same way that psychiatrists and judges themselves frequently did. My observations allowed me to identify the information that professionals actually used in decision-making, rather than the information that was theoretically available to them had they read a person's *dossier* in detail. I was able to see how they classified particular individuals on a given day in relation to the other decisions they had made at the same time. Methodologically, as Emerson (1983:425) argues, "The individual case provides an adequate unit of analysis only if social control agents themselves examine and

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[1] Coldefy, Magali and Le Neindre. 2014. *Les Disparités Territoriales d'offre et d'organisation Des Soins En Psychiatrie En France : D'une Vision Segmentée à Une Approche Systémique.* n° 558. Paris, France: Institut de recherche et documentation en économie de la santé.

dispose of cases as discrete units," whereas in truth they "process and respond to cases in relation to, or as part of, some larger, organizationally determined whole." It was clear, for example, that on days where clinics had a large number of 'heavy' cases, they looked more skeptically on less severe situations that under other circumstances might have garnered more of their attention.

Qualitative Interviews

A significant part of the data for this dissertation comes from 333 qualitative interviews, which ranged from 20 minutes to two-and-a-half hours (some thirty additional informal or short interviews, or interviews for which the recording was lost, are excluded from this total). 186 of these interviews were conducted in France, 147 in the United States (66 in New York, 81 in California).[2] I identified potential interviewees based on three target groups: 1) policymakers, regulators, and advocates operating at the national/regional/department (for France) or state/county (for the U.S.) level; 2) professionals working in the sites where I did my ethnographic observations; 3) professionals working at other organizations similar to where I was conducting field research. I also conducted about 30 follow-up interviews, particularly with individuals with whom I initially spoke with during preliminary phases of research. A summary of the professional backgrounds and institutional locations of my interviewees is given in Tables A.1 and A.2.

The population of individuals I interviewed is different in the two countries, partly by design and partly by default. First, the identification of interviewees followed differences in the relative importance of professional groups. In France, the system is dominated by a mix of people trained as administrators and psychiatrists. In the U.S., clinical social workers (MSWs, LMSWs, or LCSWs) are generally recognized as the "workhorses" (Scheffler and Kirby 2003) at the ground level and were also frequently the key actors in government agencies. Second, certain professional groups are simply more present in one country: lawyers are ubiquitous in the U.S., and not just the "judicial" sector proper. Finally, it was clearly much easier to access government actors in France than in the United States, which explains the large number of people with an "administrative" training. I started to see this as less problematic over time as I realized how many bureaucratic traces higher level actors leave behind them *and* the extent to which interviews with them tended to lack the candor of people working on direct services.

Because the goal of this research was to understand how state agencies responded to the severely mentally ill across a range of domains, I developed separate questionnaires and adapted interviews depending on organizational context. In order to create some coherency and consistency, however, I tried to close each interview with a series of questions about the weak/strong points of the system, specificity of mental health/psychiatry, goals of treatment, views on key reforms or impending legislation, and terminology used to describe people with mental illness. Although this allowed me to make some rough generalizations about interviewees in each country, responses are still difficult to compare. For example, the question of what to call people with severe mental illness was contentious in France ("*usagers*", "patients", "*malades*"), whereas in the U.S. the responses were usually boiler-plate ("patients" in hospitals, "clients" otherwise).

I recognize that, in leaning heavily on interviews, the dissertation is resting on a method that has been heavily critiqued. Jerolmack and Khan (2014:186) argue that "talk is cheap" because "explanations generated by interview data…can only reveal actors' justifications for actions that take place in unobserved contexts (the past or the future)." I certainly do recognize that interviews are better for understanding how actors justify actions *post hoc*, and I make my own conclusions about

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[2] Some of the interviews for California were carried out by research assistants.

Table A.1: Interviews By Profession

	France	**United States**
Psychiatrists	50	29
Psychologists	29	16
Nurses	10	4
Lawyers	18	37
Administration	31	*
Social Workers	21	36
Generalist Doctors	17	3
Other	10	22
Total	***186***	***147***

Table A.2: Interviews By Field

	France	**United States**
Advocacy	14	16
Municipal Government	7	5
Health	62	53
Social / Housing	64	24
Judicial	22	34
Professional Organization	7	5
Research	9	8

whether their stated reasoning was what they actually in fact relied upon based on my observations. I also found interviews useful as a way to get quick feedback on emerging hypotheses about what was happening in my field sites and, particularly in France, to get clarification on things I did not fully understand. As Rinaldo and Guhin (2019) argues, talk "is never cheap when talk has a context"—that is, when it can be used to elaborate, expand on, and sometimes challenge observational data.

Limiting qualitative research to the directly observable and interactional in the way Jerolmack and Khan propose risks confining researchers to a micro-sociology of the oppressed, who are rarely in a position to refuse ethnographic access. I certainly would have enjoyed sitting in on meetings between the Minister of Health and heads of France's Regional Health Authorities, but the fact that I could get someone in the Minister's cabinet to agree to an interview gave me information that I was unlikely to get either from available documents or observations. In general, the study of power requires more methodological eclecticism than the full ethnographic immersion sociologists have taken as their gold-standard for studying the marginalized allows.

Other Data Sources

I triangulated my interviews and observations with a variety of other data sources. Much of my historical information comes from an extensive review of primary source documents. More recent government reports and plans are available online; for others, I accessed them in hospital libraries, government archives, or through copies provided by retired policymakers or professionals.

The archives of the Ministry of Health in France were a particularly rich source of information.[3] For each country, I also monitored media coverage of mental health in major outlets throughout the course of my fieldwork and afterwards. For the research in California, I was systematic in attempting to capture all published stories on long-term care, new facilities, and the conservatorship reform in the state during the period of my fieldwork.

I spent a significant amount of time searching for data that either did not exist or was not accessible, an experience that became data in and of itself. For example, after repeated inquiries, the French Ministry of Justice insisted that they did not keep any data on judicial controls of involuntary hospitalizations prior to 2011—a sign of how *de minimis* oversight was at the time. With the help of my research assistants, we filed Freedom of Information Act requests with every state in the U.S. to get data on the total number of civil commitments in each; while most tracked the number of admissions to state hospitals, we knew this was a small proportion of total involuntary holds, which only four states claimed to compile the total number. For New York, I am confident that these data exist, but the state flatly refused to provide it. California provides some information on involuntary holds and conservatorships, but cross-checking with interviews quickly showed that the state likely under-reports the number of conservatees by 50%.

What administrative data I did obtain were particularly helpful for identifying if and how the cases I observed ethnographically were representative of the total range of clients served by a given institution. For example, for the MDPH in Paris I was able to obtain a summary of awards from 2014-15 that confirmed that both the mix of cases I saw and their outcomes were relatively representative of the tens of thousands of applications they processed in a given year. Similarly, in the California Clinic, basic information on the race, gender, and age of clients affirmed that the individuals they discussed in their weekly meetings I attended were a reasonable cross-section of their population as a group. These institutions also gave me copies of their written procedures and classification tools.

Analysis, Comparative Approach, and Case Selection

Data Analysis

The interviews and observations and a proportion of the primary source documents were open-coded in the qualitative research software Dedoose. I gradually developed codes that encompassed the key themes as they emerged. For France, I ultimately deployed 505 codes which were applied 14,120 times to 8,468 separate units of text. For the United States, the number of codes was greater because the data were split between California and New York: I ultimately applied 568 codes 11,534 times to 7,213 separate units of text. Simply allowing themes to emerge from the data and then counting the frequency with which a given code was applied revealed some patterns in itself: for example, while discussion of “rights” was ubiquitous in the U.S., it was confined to respondents operating more specifically in the judicial field in France.

My ethnographic observations were coded a second time in a more structured fashion to capture all the available information about each decision-making case. This included demographic and diagnostic characteristics about a given individual. More importantly, though, I developed categories to capture the reasoning and justifications deployed by professionals in making disposition decisions (like assigning a level of care or deciding whether to release someone from the hospital). Here, I deliberately sought to use common categories across the two countries, when possible, to facilitate comparison. I double coded each set of observations as a reliability check.

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[3] I am grateful to Jean-Paul Brière in the Ministry of Health and Marie-Odile Safon at *l'Institut de recherche et documentation en économie de la santé* for their help in accessing these materials.

This second phase of analysis was oriented towards theory testing. I was particularly interested in the role of diagnosis in decision-making and the degree to which different professionals used similar heuristics in each country versus categories being shared primarily by similar professionals between the two countries. The fact that I found common categories underpinning decision-making in disparate contexts within France and the United States is central to my argument for the centrality of the state in creating consistency in classification.

In this respect, the dissertation followed the precepts of the extended case method (Burawoy 1998). Rather than trying to bracket out structure and history to focus on observable interactions, I used my non-ethnographic data to understand the "macro conditions of micro processes" (Burawoy 2017:275). My approach is thus an argument for using theoretically-informed comparisons and non-observational data sources to produce a "structural ethnography," one which pushes back on the tendency (Desmond 2014) to focus primarily on relationships, interactions, and the faithful reproduction of the lived experience and perceptions of research subjects.

Comparative Logic

Initially, this project envisioned building on multi-national studies of the organization of mental health care that have used as dependent variables the number of beds in psychiatric hospitals or anti-depressant usage and considered their relationship to welfare regimes or health systems (see Goodwin 1997; Olafsdottir 2007). I quickly discovered just how frustrating constructing a coherent cross-national data set on mental health services can be. Germany, for example, seems like a necessary case for any analysis of Western psychiatric systems. According to the WHO, the country has 15 psychiatrists per 100,000 people—fewer the France, and about the same as in the U.S. The OECD pegs the number at 27, which is more than any country save Switzerland. The two sources offer an equally expansive range for beds—from 52 per 100,000 (in the middle between the U.S. and France) to 121 (well above the latter).

Data on France and the U.S. are also inconsistent, but with enough effort, I can parse out why. Different kinds of beds are counted as "hospitals" in different surveys, for example, and substance abuse treatment is counted in some datasets on mental health spending and not in others. I cannot do that for every country, however. The end result is that I use the data presented in the Introduction to contextualize my two cases, but do not offer any more detailed analysis based on numbers in whose precision I do not have confidence. And if counts are different for something as straightforward as the number of psychiatrists, I have even less faith in cross-national epidemiological studies making much fuzzier claims about the prevalence of conditions like anxiety and depression.[4]

Why, then, bother with comparing the two countries? One use of comparison is to isolate causal factors by carefully matching countries along a number of characteristics and focusing on an outcome and a small number of independent variables that vary between them. One set up that I frequently used in framing the study was to emphasize that the U.S. and France, as of the 1960s, had similar custodial asylum systems. From that point forward, they diverged radically in the degree to which they de-institutionalized, creating two systems in which the relative weight of the health system in the social trajectories of the severely mentally disordered varied substantially. What I realized over time, though, is that, if the systems were similar in the 1960s, it was a superficial moment of convergence in persistently different historical trajectories. In the U.S., asylums emerged primarily as an institution of charity; in France, they were constructed to provide a mix of medical

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[4] The best attempt to create such comparable data is from Kessler et al.'s World Mental Health Survey (Üstün and Kessler 2008) (see Inset in the Introduction).

care and social control. And if they were both in "crisis" by the 1950s, in France this was a result of mass death during World War II, to which even the worst exposés of the American state hospitals could find no parallel.

Ultimately, the focus of this research is to identify the institutional and social structures that connect superficially divergent official classifications, inconsistent practices for applying them, and conflicted public policies into "fairly coherent constellations" (Fourcade 2009:13) at the national level. Working comparatively was crucial for finding this coherency in chaos. For France, it gave me some critical perspective on the narratives of change I heard over and over again. Consistent with notions of a neo-liberal convergence of health systems (see, e.g., Beckfield et al. 2013; Glennerster and Lieberman 2011), French actors told me that the country had a penury of psychiatric beds and a demographic crisis of psychiatrists. To them, the mentally ill were spilling onto the streets and locked in prisons in droves; ideas of "recovery" and "peer supports" were ascendant. From their perspective, this may have been true, but from mine, what was interesting was why there were comparatively so *many* beds, so *few* mentally ill in prisons, so *little* embrace of recovery. When I returned to the U.S., comparative research helped me de-naturalize the system and break with the "common sense" about it I held as an American. Having spent fifteen months in the field in France, I asked myself, "why *isn't* this person being hospitalized?" and my informants in sites like the California clinic, in turn, started asking me, "would he be hospitalized in France?"

Ultimately, mine is closest to what Mahoney (1999:1168) would call a "narrative" rather than variable-oriented approach to comparative research. "One criterion for judging" research under this approach is "the ability of an analyst to meaningfully assemble specific information concerning the histories of cases into coherent processes." In constructing these constellations, I have leaned heavily on a comparative literature on the role of the state, professional authority, and the relationship of the individual to the collective in France and the United States (see, e.g., Carson 2007; Dobbin 1994; Lamont 2000; Porter 1996; Saguy 2003). In part, I see the validity of my research in the congruency of my results with this literature (rather than through the wholesale novelty of my findings).

As a final comparative note: my two cases are not fully independent, but probably not as linked as I might have thought. After all, psychiatry is a global discipline, the DSM is used around the world, pharmaceutical companies have global reach, and organizations like the OECD and WHO push a fairly coherent set of policies, which governments across the developed world adopt, at least rhetorically (Shen and Snowden 2014). Although both anti-psychotics and the model of the *secteur* flowed westward across the Atlantic in the 1960s, in the contemporary U.S., I heard virtually no discussion of foreign models (except from the occasional foreign psychiatrist).[5] In France, on the other hand, I saw the persisting "attraction of attention of the American health system, less for its organization—more or less decried—as its capacity to produce seductive innovations" (Benamouzig 2005:390). Most of my French informants probably had a more dire picture about the state of American health care (such as the number of uninsured) than the data bear out. But, at least in the Ministry, Assertive Community Treatment teams, peer supports, clubhouses, or early intervention into psychosis campaigns were all attractive models developed in the U.S. (even if, frequently, they passed through Quebec).

For many on the ground, the Americanization of the French mental health system was something to be feared, threatening France's self-styled position as the rich-world counterweight to

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[5] As Levitsky (2008:573) found in asking family advocates about foreign systems that provided greater support for the entourage of people with chronic illness, "participants understood the health care systems of other countries to be so different from health care provision in the United States that international comparisons ultimately failed to resonate."

American cultural (and in this case, psychiatric) hegemony (DeSoucey 2010; Saguy 2003). As one former psychiatric nurse who had worked on policy reforms told me: "When we look at the U.S., there's a huge amount of fear of the 'externalization' of [mentally ill] persons, a risk of just abandonment, of pushing them out of the medical system into homelessness. So there's a very strong distrust" (Interview, 8/23/16) of foreign models. French psychiatrists, in particular, saw themselves as a last bastion of defense for psychoanalysis, with its interest in inner subjectivity, in the face of an ascendant neuro-biological psychiatry focused on controlling external behaviors. Ultimately, this dissertation joins those challenging "the now commonplace narrative of psychiatry as an increasingly standardized, global, biological science" by pointing to "how uneven, context-specific, and frictional the global development of bio-psychiatry has in fact been" (E. A. Davis 2018:5).

Levels of Analysis

In the U.S., the federal government's most important role is in financing, through Medicaid dollars, that pay the largest share of mental health treatment costs, and social security disability income, which has played a huge role in financing life for patients outside the state hospitals. Some policy around these entitlements is explicitly around mental health, as is the case for the famous IMD exclusion that bars federal funds from specialty psychiatric hospitals. In general, though, this federal money comes disconnected from any clear policy direction. Although my informants also sometimes referenced priorities financed directly through the Substance Abuse and Mental Health Services Administration (SAMHSA), the "national" level appeared more in terms of American culture and the broader American welfare state, rather than direct mental health policy.

Arguably, then, the U.S. thus does not have one mental health system—it has fifty. As I mention throughout, California and New York are at something of two opposite poles, while still having some explicit "model" (as opposed to states where "policy" seems limited to wholesale neglect). New York once had the country's most extensive systems of state hospitals, peaking at nearly a fifth of all the country's psychiatric inpatient beds. Many of those beds have disappeared, but the approach to mental illness has some stability: the state continues to have a well-funded inpatient and outpatient system that serves even more of the adult population than the French *secteurs*. It has been relatively late to "rationalize" and restrict care. California represents another vision: a hospital system with fewer beds, a decentralized public outpatient system that serves fewer people, and a legal system that is less paternalistic and more protective of patient's negative rights. The continuities between how actors in these two systems talk about, classify, and respond to mentally ill people speak to common national patterns that exist despite differences in legal standards and institutional resources.

No French person would say that a study that centers on Paris is representative of the entire country (which is part of why I conducted interviews and site visits outside of the city). Much like New York City and San Francisco, psychiatry in Paris is particularly well-resourced, even if the challenges it faces (in terms of homelessness and disruptive behavior) are accentuated. Because in France I was focused specifically on three sets of reforms (the attempted integration of psychiatry into the broader healthcare field in 2009/2016, the reform of the disability system in 2005, and the introduction of judicial controls in 2011), analyzing Paris allowed me to study the place where most actors thought these reforms had the greatest chance of success, owing to the intense scrutiny of government actors and concentration of advocacy organizations. The fact that all three struggled so much in Paris, in my reading, suggests that durability of patterns of institutional responses to mental illness, even in the face of explicit changes to policy.

Limitations

In claiming to study the "mental health system" in two countries, this one is vulnerable to the criticism that it leaves out many of the actors and institutions that the topic most readily brings to mind. My research design gives little voice to mentally disordered persons themselves and deliberately puts to the side private mental health services and those for children (except when they transition into the public, adult system).[6] I myself am surprised to have so little to say about pharmaceutical companies. Some of the absences are actually findings: for example, the anti-psychiatric movement makes few appearances, because it seems to have had few impacts. I elaborate and explain these decisions about what to exclude from the scope of this dissertation in this section.

Medication and the Pharmaceutical Industry

Pharmaceutical treatment is as central to the management of people with severe mental disorders as the asylum was a half-century ago (see Gong 2017; Jenkins 2015; Ricciardelli and Huey 2016). One American psychiatrist recounted, "I'd like to say I hope that my patients live a life of meaning. But, in practice, my goal is to keep people out of the hospital. That means stable, which means taking meds. I'm a broken record: 'take your meds, take your meds'" (Interview, 12/8/16). Even in France, where psychiatrists continued to play managerial and therapeutic roles beyond prescribing, their central role was nonetheless clear. The head of the *secteur* I studied insisted:

> I have a psycho-analytic training…But our first missions, it's to be a doctor and prescribe. We need to be good at it…After that, they [psychiatrists in the *secteur*] can do what they want. You can add what you want to decorate…[But] the core of our profession is to treat [with medication] so people can function (Interview, 6/28/16).

This "first mission" might seem to get short shrift in this dissertation, for a few reasons.

First, although rates of anti-depressant consumption vary substantially, for schizophrenia, the use of anti-psychotics is fairly universal (although my French informants believed that Americans preferred long-acting injectable medications that required less patient-provider contact) (Haro et al. 2003). For me, the more interesting question is where that medication is actually delivered. In the celebrated model of Assertive Community Treatment in the U.S., injections can be given under a bridge or in a McDonald's bathroom; many of course, take their anti-psychotics in prison. If the location of treatment was something clinicians were trying to make irrelevant, it seems to me like the crucial point of comparison between my cases.

Second, actors in both countries were well-aware that even "newer," second generation anti-psychotics were only minimally improvements from the drugs invented in the 1950s (Lieberman et al. 2005).[7] This dissertation focuses thus on the question of "what next"—what clinicians do when clients do take their medication and don't get better, stabilize but continue to struggle to survive in the community, or refuse medication entirely and legal mechanisms to override that refusal are lacking. It is in clinicians' solutions to those problems *not* resolved by medications that the biggest cross-national differences emerge.

A slightly different question is about the role of "biomedical industrial complex" (Gomory et al. 2011:137) itself, an easy foil for a host of critical books on its unscrupulous marketing,

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[6] I do not discuss children even in this limitations section. My intuition is that the children's system in the U.S. is marginally better than that for adults, owing to a greater evaluation of "deservingness" and an aggressive focus on early identification and intervention. In France, the penury of pedo-psychiatrists and enormous conflagrations over autism portray a sector even more beleaguered that that for adults.

[7] Except for Clozaril, which was both more efficacious and more dangerous, making it a drug of last resort I heard about mostly in inpatient settings; its billing as a "miracle drug" that brings patients "back to life" is chronicled by Jenkins (2015).

manipulation of regulators, and co-optation of doctors.[8] Those studies largely are focused on the mild-to-moderate side of the continuum, with particular attention to anti-depressants. In the public system in the U.S., I heard occasional complaints about the companies' excessive influence on psychiatric training and gripes that some of the newest formulations (like a three-month injection of Abilify, for $5000) were outside their price range. The occasional pamphlets and advertisements I saw sitting on clinician's desks spoke to the "blockbuster" economic status of anti-psychotics, which are now the most profitable class of drugs in the U.S. (despite accounting for only about one-fifth as many prescriptions as anti-depressants) (Dumit 2018).

Surprisingly, though, new drug trials for anti-psychotics have collapsed 60% in a decade in the U.S. (O'Brien et al. 2014; E. F. Torrey et al. 2017) and shown a similar decline in France (Leboyer and Llorca 2018). As research on anti-depressants plateaued into reformatted versions of drugs acting though the same mechanism (serotonin), most have slid into generic form and more prescriptions have ceased to mean more profits.[9] Pharmaceutical companies clearly see the same thing coming for anti-psychotics. The CEO of GlaxoSmithKline described mental illnesses as an arena where "we believe the probability of success is relatively low…and the cost of attaining success is disproportionately high" (qtd. in Dumit 2018:61). One read is that the mentally ill are once again victims of their specificity—that brain diseases are, in fact, not like other illnesses, and the difficulty of understanding their origins translates into a difficulty in finding treatments. A simpler one is that schizophrenia is basically rare and its sufferers are poor. In any case, I heard little about the pharma industry either from practitioners and policymakers.[10] They neither attributed the ills of the present system to corporate malfeasance nor framed their hopes for the future around new miracle drugs.

Anti-Psychiatry, 'Users' and Patients' Movements

Both my informants and my academic interlocutors have frequently asked, "What about the views of the mentally ill themselves? Did you interview them?" The answer is, with the exception of a few prominent service users in associations for people with mental illness, "no." This could seem like a major gap in a dissertation that claims to analyze the construction of the personhood of the severely mentally ill. Sociologists have embraced the agency of the mad by moving away from an older perspective that saw "mental illness" as a classification unilaterally imposed through a process of "labeling" (Goffman 1961; Scheff 1999 [1966]) to analyzing "looping," or the dynamic ways that people respond to being classified.

People with severe mental disorders are prime examples of how people may "rebel against the knowers, the classifiers, the science that classifies" (Hacking 1998:239) and force a reevaluation of those categories. I discuss these classification struggles both historically and in real time as clinics cajole patients to come to appointments, disability evaluators demand people furnish information about their limitations they are reluctant to give, and lawyers and judges negotiate with involuntarily hospitalized patients to ensure minimum compliance. These responses challenge both how professionals set the boundaries of the "state kinds" they work with and the interventions they are likely to see as efficacious for other clients. Like other studies using the concept of looping (Eyal

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[8] Any list is necessarily partial (Greenberg 2010; Healy 1997; Pignarre 2003; Whitaker 2011).

[9] According to SAMHSA, this shift is a major driver of slowed growth of mental health spending—which could, in a more patient-centered system, be seen as a good thing. SAMHSA, *Projections of National Expenditures*: iv.

[10] One other influence of pharma is through the financing of patients' and families' movements in the U.S. The head of UNAFAM, the parents' organization in France, proudly told me that she refused financing from pharmaceutical companies (Interview, 9/3/15), which is easier to do in context where the state subsidizes patients' groups in the name of "health democracy."

2010; Loveman 2014; Navon and Eyal 2016), I argue that I can get purchase on these processes by looking at bureaucratic traces and professional responses to the actions of the severely mentally disordered, without delving into their subjective experiences.

This dissertation has a relative paucity of references to anti-psychiatry and patients' movements. For France, the reason is straightforward. *Sectorisation* was a process driven by psychiatrists themselves (Henckes 2011b:172), whose reforms in response to the tragedy of World War II may have headed off some anti-psychiatric critiques.[11] Foucault's intellectual influence aside, a critique of psychiatric institutions was relatively marginal to the upheavals of 1968 and the far-left never embraced anti-psychiatry, like it did in Italy (Donnelly 1992; Scheper-Hughes and Lovell 1986).[12] One interviewee described her experience after what she described as an abusive and unjustified hospitalization:

> I thought to myself, there must be some political movement, a union, something that fights for these people, against what I saw, because it was just impossible. There must be movements everywhere in France! And I looked, and they didn't exist anywhere…I wrote the so called 'militant' or 'revolutionary' psychiatrists, and I didn't get a response (Interview, 8/21/16).

She eventually found the *Groupe information asiles*, which actually did have an important role (discussed in Chapter 4) in bringing successful litigation to the European Court of Human Rights and French Constitutional Council challenging the lack of judicial review of involuntary hospitalizations. This belies the idea that anti-psychiatry "had no practical consequences" (Ayme 1995:13) in the country. But the GIA did it with around four, very dedicated, members.

The rise of "health democracy" in France has encouraged attempts to incorporate "users" into hospital oversight counsels, local mental health boards, and national policy discussions (Caria 2009; Fayard, Caria, and Loubières 2011). For the latter, this nearly always meant inviting the woman who headed France's National Federation of Psychiatric Users' Groups (FNAPSY). "If you need to have a representative, you have to invite her" (Interview, 2/22/16), one interviewee noted. When she was sick—which, in order to fill this role, she necessarily was at times—that seat often went unfilled. Another manifestation of health democracy was a new training program started in 2010 for "peer-supports" (Gardien and Laval 2019). At a public event, one of its advocates explained, "This is something that comes from the U.S., from North America, and it makes sense, but it's pretty shocking to the health professionals. So even when they're incorporated into the team, they remain in the box of 'patient'" (Fieldnotes, 5/12/16). There were no peers working in my field sites.

In the U.S., the anti-psychiatric movement was arguably more influential, although its role in a de-institutionalization process that was driven more by fiscal pressures than civil rights litigation is contested (see Appelbaum 1994; Grob and Goldman 2006). But in my field research, the role of "consumers" seemed limited. Within psychiatric services themselves, professionals were more likely than those in France to tell me, as one social worker explained that, "our biggest untapped resource is our clients, and their ability to provide community and mutual support for one another" (Interview, 3/15/19). The expansion of peer supports—as part of the "task shifting" away from more expensive professionals discussed in Chapter 1—has clearly gone further in the U.S., although peers did not participate in any of the decision-making contexts I observed ethnographically.

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[11] Roudinesco (1990) also credits Jacques Lacan with rehabilitating psychiatry in the public eye and linking it to an anti-institutional critique that neutralized some of the attacks anti-psychiatry could make.

[12] One intriguing hypothesis which I have absolutely no capacity to evaluate is that the Italian communist party was "non-aligned," while French communists remained tied to Moscow, which was busy using psychiatric diagnoses like "sluggish schizophrenia" to intern dissidents (Zajicek 2018).

Ultimately, I certainly appreciate the constant pressure to include the silenced voices of the marginalized and the oppressed, among whom the severely mentally ill are sadly prominent (see Jones and Brown 2012). But our desire to recovery the agency of the mad should not obscure how little the system actually grants them:

> There are gross imbalances of power and resources at work here…where the problems of social subordination and economy powerlessness are compounded to an extraordinary degree by the impact of the label of insanity. For the lunatic, the madman, the psychotic, the schizophrenic…suffer a sort of social and moral death. Their wishes and will, their very status as moral actors, as agents capable of expressing valid preferences, and exercising autonomous choice are deeply suspect in light of their presumed pathology, as the often dark history of their treatment under confinement abundantly shows (Scull 2006:52).

Most of the thousands of determinations about the institutional disposition of people with severe mental disorders I observed in the two countries were taken outside the presence of those more directly concerned. Claiming otherwise in the name of "relational ethnography" (Desmond 2014) does not change that a hallmark of bureaucracy is that many decisions are made *without* any meaningful relationship between the decider and the decidee.

Private Care and Prisons

Private health care and the criminal justice system seem like two polar ends of the mental health system, but their relationship to this dissertation is similar. For each, I study their boundaries with the public mental health system without delving into their interior. Dirigiste narratives aside, France has one of the largest private hospital systems in Europe and nearly all ambulatory doctors are private practitioners (Hassenteufel 1997; Steffen 2016; Wilsford 1991). The *secteur* policy, however, gave the state a particularly pronounced role in mental health care by assigning *secteurs* responsibilities for community consultations and requiring no payment from patients or their insurance.[13] The *secteur* system violated the doctrine of "free choice" of a doctors central to liberal medicine, because patients were supposed to go to "their" *secteur,* as determined by their address. On the other hand, nearly half of psychiatrists primarily give consultations in the "liberal" sector and for-profit private hospitals account for a quarter of psychiatry beds (and their proportion is growing).[14] The Sarkozy government and 2016 health law both attempted to boost the role of private actors in the mental health system by including them in planning that traditionally revolved around the *secteurs.*

Most of my informants, though, described these as "two worlds that ignore each other" (Interview, 2/28/16). For-profit private hospitals primarily take patients with depression, eating disorders, and alcoholism—not psychosis—and cannot receive involuntary patients (Leboyer and Llorca 2018:88).[15] With the exception of a few of the schizophrenic sons and daughters of the French bourgeoisie who "organized their entire *parcours* through private clinics and liberal psychiatrists, to avoid the *secteurs,* which they see as really for the heavy mentally ill" (Interview, 7/26/16), the dominant assumption was that "real *malades*" would enter and stay in the public system. I did see an ongoing interaction between public and private in my ethnography of a public

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[13] This is true for consultations at the CMP. Hospitalization, the *secteur* social workers reminded me, was not free, even if most patients sojourns were paid for by Social Security or a *Mutuelle* insurance.

[14] Lopez and Turan-Pelletier, *Organisation et fonctionnement du dispositif de soins psychiatriques.*

[15] It should be noted, though, that private hospitals have been the origin of some of the medications now used in the public *secteurs,* and played an important role in "institutional psychotherapy," which became the basis for reforms to the public hospital sector (Caussé 2016; Cléry-Melin 2002).

clinic, where 16% of patients were referred from private providers and 12% were referred back to them (see Table 1.3). Still, public psychiatry remains a "primary care provider" for psychiatric illnesses, unlike other specialists where patients are expected to pass through a generalist first.[16] The huge number of psychotropic drugs prescribed by generalist doctors were, in the eyes of many public psychiatrists, not even treatments for "mental illnesses" per se, but for minor psychic troubles in response to aging, poverty, or unfortunate life events which were outside their ken.

I saw the boundaries between the health system and the law in my observations of clinics and involuntary commitment courts, as well as interviews with psychiatrists in the Parisian Psychiatric Infirmary of the Prefecture of Police.[17] For a long time, the boundaries between "health" and "justice" were relatively impermeable. Although cases of "penal irresponsibility" were an object of particular fascination for Foucault (1981), they account for less than 1% of involuntary entries into psychiatric hospitals.[18] Some French scholars have charted an increase in judges imposing an "obligation for care" on persons passing through the justice system (Marques et al. 2016). But in my observation sites, it was clear that psychiatrists saw their role as keeping people who were "*caractériel*" [trans?] or "psychopaths" *out* of the health system, not medicalizing their deviance. The *secteur* occasionally relied on the police to help them hospitalize persons who were locked in their homes, refusing care. But cooperation did not go the other way: "the police can be intrusive, and that is a serious problem for me. I'm not going to give the forces of order information about a patient," a social worker told me (Interview, 3/7/16). When the police entered the clinic to arrest a *secteur* patient who had been shouting about "jihad" (this was shortly after the 2015 terrorist attacks), the team was outraged. "This is a place of care, a sacralized place" one nurse exclaimed (Fieldnotes, 2/26/16).

As in the U.S., many informants lamented that "there are a lot of psychotics in prison" (Interview, 3/20/16). This observation was supported by the one real study on the subject (in 2004) which put the prevalence at 3.8% for schizophrenia, 17.9% for major depression, 17.7% for anxiety, and 10.8% for drug dependence. It claimed the proportion was higher than most European countries (Falissard et al. 2006). Since the 1980s, there are small *secteurs* that served in penitentiaries, but the general discourse has largely been that "there should be a radical separation between care, which belongs to psychiatry and medicine, and internment and control, which belongs in the domain of justice" (Roelandt 2009:529).[19] From this conception, a prisoner transferred to a public hospital was not really a prisoner any more, but a *malade*.[20] These barriers have clearly started to break down with the creation of specialized prison-hospitals under a joint health-justice oversight, and the creation of hyper-secured hospital units as part of the overall "securitarian turn" (Eyraud and Moreau 2013:118; see, also, Collectif Contrast 2016; Eyraud and Velpry 2012). This dissertation discusses more the general resistance to these transformations than the rise of these new institutions.

In the United States, the boundaries between the public and private systems are much fuzzier. Into the 1950s, the public system essentially *was* the mental health system: 88% of "patient

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[16] According to one report, France has one of the lowest referral rates from primary care providers to psychiatrists in Europe. Laforcade, *Rapport relatif à la santé mentale*: 45.

[17] My informants in the disability system were insistent that the judicial histories of persons with handicaps had no relevance whatsoever for their work. "They do their work, and need to let us do ours" (Interview, 1/22/16).

[18] Haute Autorité de Santé. 2015. *Protocoles pour la rédaction des certificats dans le cadre des soins sans consentement. Note de cadrage.* Paris, France: HAS: Service des bonnes pratiques professionnelles: 6-7.

[19] France has been criticized internationally for doing little to divert potentially mentally-ill offenders from prison (Dressing, Salize, and Gordon 2007).

[20] For example, a 1997 report states that "detained persons in a state of mental alienation cannot be kept in a penitentiary establishment." Strohl and Clemente *Rapport du groupe national d'évaluation de la loi du 27 juin 1990*: 37.

care episodes" took place in state hospitals and two-thirds of psychiatrists worked there as state employees. Those in private practice served a small clientele that could pay out of pocket (Grob and Goldman 2006:14). De-institutionalization created a more even dual-track system: states continued to have specialty mental health departments that operated in conjunction with Medicaid and Medicare funds, largely separate from an expanding system of office-based psychiatrists and private hospitals. Into the 1980s, "the private medical care system…[was] far from the lives of most persons with chronic mental illness" (Hollingsworth 1992:902).

In the last two decades, however, "the traditional public-private divide has been blurred" (Miller and Hanson 2016:134). With cuts to the Community Mental Health Centers in the 1980s, a system of true public provisioning of outpatient care analogous to France has become a road officially not taken. States increasingly rely on private insurance companies to manage public Medicaid funds, which flow primarily to private non-profit clinics (Brown and Cooksey 1989; Frank and Glied 2006; Maskovsky 2000). As for-profit entities control more and more hospital beds (Reich 2014b; Scott et al. 2000), the public power of civil commitment and conservatorship is now exercised in private facilities (see Chapter 3). When I speak of "public mental health care" in this dissertation, thus, I am not really talking about the private/public status of treating entities. Mostly, by "public" I mean institutions that have a mission of serving the severely mentally ill, which usually also means people with public insurance.[21] Because no one in my field sites expected the severely mentally ill to get jobs with health insurance anytime soon, the actual boundaries between this hybrid public-private system and the truly private one were not that much more porous than in France.

Jails and prisons are unlike private hospitals or board-and-care homes in that they could not say "no" to difficult clients and thus are the closest to a truly "public" provider in the U.S. (Sufrin 2017). The extent to which state hospital residents moved directly into prisons is debated (Harcourt 2005; Liska et al. 1999; Roth 2018), because most state hospital residents were old and white and those in prisons are disproportionately young and black. The best estimate suggests that trans-institutionalization accounted for 4-7% of the growth in prison populations since the 1970s (Raphael and Stoll 2013:219). Still, a conservative estimate for the rate proportion of people in prisons with severe mental illnesses is 113 per 100,000 U.S. adults (Lamb and Weinberger 2005:529), three times that in France.[22] Although the number of persons in U.S. prisons and jails is declining (notably in California), some have speculated that people with severe mental illness may actually be slow to be released for lack of availability of "safe" community placements (Roth 2018).[23]

Given the number of mentally ill inmates, the absence of a discussion of the care actually being delivered *in* jails is an important lacuna. Still, I examine the boundaries with the criminal justice across multiple field sites. The clinicians in Chapter 1 worked to keep their clients out of jail but also

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[21] Although some of the institutions I studied used to serve large number of uninsured clients, post-ACA most clients in the clinic I studied either had or would have insurance (surprisingly, there were few new cases flagged as being undocumented). This would presumably be different in states that did not expand Medicaid.

[22] Calculation based on Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT). 2012. *Rapport au gouvernement de la République Française relatif à la visite effectuée en France du 28 novembre au 10 décembre 2010*. Strasbourg, France: Conseil de l'Europe. The number given in the report above is a rough estimate and probably more expansive in its definition of "mental illness" than those used in the U.S. studies.

[23] A recent lawsuit in New York State contends that five inmates were held past their release dates because they need "a supportive housing facility, but there is not one available" and the state "determined they are likely to be homeless once released." Southall, Ashley. January 24, 2019. "Mentally Ill Prisoners Are Held Past Release Dates, Lawsuit Claims." *The New York Times*. Retrieved April 30, 2019 (https://www.nytimes.com/2019/01/23/nyregion/prisoners-mentally-ill-lawsuit.html).

seize on arrests as a chance to engage clients while they are a "captive audience." In Chapter 3, I examined how conservators struggle, in particular, to find placements for criminal-justice involved clients with violent histories. The hearings I analyze in Chapter 4 included those for "forensic" cases that had been transferred to the hospital from the city jail.

Across sites, I see a tension that is worth analyzing further, if not in this dissertation. On one hand, interviewees in both states identified the incarceration of the mentally ill as a problem and celebrated the proliferation of "diversion" programs. The head of a New York taskforce explained:

> Under the last administration, police officials didn't want to talk about mental health…but now there's a real openness to how officers can interact differently…There are something like 150,000 calls a year that the police department codes as 'emotionally disturbed persons.' But only 1.2% of those ends in an arrest! We are doing a really good job not arresting people who are in psychiatric crises, and it's helped cut the jail population dramatically. Hallelujah! (Interview, 1/16/17).

On the other hand, as with the push for the mental health system to address drug use and homelessness, some clinicians felt that policymakers expected them to deal with people who were ultimately criminals but whom the police did not want the hassle of booking (see Seim 2017; Stuart 2014). One ER psychiatrist explained:

> The old status quo was, if you violate the norms of society, and act inappropriately, you go to jail. The new status quo seems to be: if there is some moderate likelihood the behavior is related to mental illness, rather than going to jail, there is a substantial effort to get them into mental health services. By and large, that's the right way to handle it. The problem is when you have people who are mentally ill and criminals, and the criminality isn't tied to mental illness, and so treatment won't stop that behavior (Interview, 11/30/16).

As another forensic psychiatrist told me, "we're not terribly good at treating people who want to break noses, but we're pretty good at treating people with schizophrenia" (Interview, 12/6/16). Landmark moves like the decision of L.A. County to build a new hospital for jail inmates, rather than new mental health units in a jail,[24] will have to contend not just with the literal policing of the mentally ill, but also the policing of the boundaries of mental illness by health professionals.

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[24] Lau, Maya. February 13, 2019. "In Landmark Move, L.A. County Will Replace Men's Central Jail with Mental Health Hospital for Inmates." *Los Angeles Times*. Retrieved April 30, 2019 (https://www.latimes.com/local/lanow/la-me-jail-construction-20190212-story.html).

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