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Discretionary Acts Fueled by Bureaucratic Anxieties: The Policing of Community-Disrupting
Mental Illness

A thesis submitted in partial satisfaction of the requirements for the degree Master of Arts in
Anthropology

by

Blake Robert Erickson

2018

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ABSTRACT OF THE THESIS

Discretionary Acts Fueled by Bureaucratic Anxieties: The Policing of Community-Disrupting Mental Illness

by

Blake Robert Erickson

Master of Arts in Anthropology

University of California, Los Angeles, 2018

Professor Laurie K. Hart, Chair

(This thesis explores the police role in diverting street-based, severely mentally ill individuals to the hospital for psychiatric assessment. Four illustrative ethnographic accounts drawn from participant observation fieldwork are presented. Analysis focuses on police discretion - the latitude for police coercive intervention – in the form of physical constraint when working with Department of Mental Health (DMH) social workers to place and negotiate hospitalization holds (“flash hospitalizations”) on acutely psychotic psychiatric patients. Police are found to frame physical constraint as a liability and danger to themselves and mentally ill clients. They also refer to the futility of flash hospitalization efforts in the face of chronic mental illness. They employ these anxieties of liability, danger, and futility rhetorically in order to communicate to DMH social workers and family members of the mentally ill the limits of police intervention in flash hospitalization scenarios. Ultimately, these anxieties derive from the way in

which the police, as a bureaucratic institution, views mental health care, a field that is not based in police carceral expertise. These anxieties exist in the context of influential, socio-political movements of the 2010s, including Black Lives Matter, which have brought increased public scrutiny to street-based police actions).

The thesis of Blake Robert Erickson is approved.

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University of California, Los Angeles

2018

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Discretionary Acts Fueled by Bureaucratic Anxieties: The Policing of Community- Disrupting Mental Illness

Police officers play a vital role in triaging mental illness in urban America. Along with social workers, the police are called upon to assess acutely mentally ill individuals in the community and determine whether to send these individuals to the hospital for psychiatric assessment. The primary focus of this analysis is the way in which a bureaucracy (the police) – the bureaucracy with the monopoly of physical force in the United States – manages erratic and potentially violent public behavior in the context of street-based mental illness.

Michael Lipsky (2010, 3) defines street-level bureaucrats as “public service workers who interact with citizens in the course of their jobs, and who have substantial discretion in the execution of their work.” He notes that, “when taken together the individual decisions of these workers become, or add up to, agency policy [...] the discretionary actions of public employees are the benefits and sanctions of government programs.” Police officers are the definition of street-level bureaucrats in modern-day, urban America. Their individual legal interpretations and enforcements, when considered collectively, effectively determine agency policy. In the context of street-based mental illness, these decisions are made in face-to-face interactions between the police and acutely mentally ill individuals. This is not a Weberian, iron cage “bureaucratic ideal of impersonal detachment in [rational] decision making” (Lipsky 2010, 9; Weber 1930). The decisions made by police officers in these highly personal, micro contexts are the focus of this paper.

As noted by sociologist Linda Teplin (1986, 1), “Police involvement with the mentally ill may be traced to common law and is grounded within two legal principles: (1) the police power

function, i.e., to protect the safety and welfare of the public; and (2) *parens patriae*, which involves protection for the disabled citizen.” With calls for mental health-specific policing on the rise, police departments throughout the country have partnered with knowledgeable specialists at Departments of Mental Health (DMH). One result of these partnerships has been the creation of specialized teams, consisting of DMH social workers and police officers, that respond to mental health crisis calls within given jurisdictions (Hails and Borum 2003; Steadman and Morrisette 2016; Steadman et al. 2000). In many settings, DMH social workers also work outside of police departments, where they have been granted the authority to place community-based patients on hospitalization holds independent of police assessment.

My exploration of police interactions with community-based mental illness is thus also a conversation about the integration of two bureaucratic orders, DMH and the police. This integration not only refers to the side-by-side, cooperative partnerships that have formed between these entities, but also to the overlapping nature of police and social worker outreach and mental health assessment. With DMH social workers at their side and/or independently writing hospitalization holds in the field, police officers do not have complete decision-making power in many street-based mental health situations.

From a medical point of view, the police have never had authority over psychiatric hospitalization itself. This decision has always been delegated to emergency room physicians and inpatient psychiatrists, who decide whether a patient should be admitted to the hospital and for what duration. What police have had, and continue to have, authority over is criminal incarceration. In managing the streets, the police utilize law and order tactics to quell disorder. What makes the mental health hospitalization hold so interesting is that it comprises a territory that it is not clearly medical or carceral in nature. This conceptual quagmire manifests in varying

degrees of police rejection of DMH social workers' actions, as evidenced by police officers' questioning of and refusal to assist DMH social workers with the processing of "flash hospitalizations" (emergency holds written by licensed DMH social workers that send mentally ill individuals to the hospital for psychiatric assessment). As noted by Paul Brodwin (2013, 163-164) in his study of psychiatric social workers,

A successful emergency detention requires careful planning and skillful negotiations with the police. [...] Emergency detention is a bulky instrument. The case managers must accumulate evidence and convince the police to intervene, but the police do not understand mental illness, and they do not appreciate the danger of ignoring the problem. With each new ED [Emergency Detention], people retell old frustrations about the obtuse inaction of police. In some stories, the police misinterpret a psychotic break for simple anger over cash disbursement. In others they refuse detention and instead issue a ticket for disorderly conduct, or refuse to take any action at all because the client has calmed down and no longer seems dangerous. Such responses infuriate clinicians. They see a client in crisis and at real risk of harming herself, but the police block them from responding.

This planning, negotiation, and accumulation of evidence is especially important when social workers attempt flash hospitalizations. While legally justified to write these holds, social workers must often call the police for assistance to physically engage mentally ill individuals in order to ensure that these individuals are transported to the hospital. Social workers must thus convince the police, who serve as de facto arbitrators of street-based mental illness due to their power to "go hands on" (to physically restrain), to transport psychiatric patients to the hospital for assessment. In these scenarios, social workers can face police challenges and possible refusal to assist in the hold process.

These moments of debate occur when the police perceive a given DMH mental health hospitalization hold as a "bad call." As noted by Peter Moskos in his study of urban policing (2008, 107), "bad calls" entail time commitments that police officers perceive as outside their current priorities. Beyond the time struggle itself, however, I argue that the police are especially

prone to label cases as “bad calls” when they are not considered experts in the area in which they are called for assistance. Unlike with drugs and crime, the police are not assumed to have expertise in mental health. Police officers mostly avoid mental health court hearings, where their opinion is often lightly considered, if at all. Without any real impact on medical or legal processes, the police fulfill a decidedly custodial role in mental health care (Rogers 1990). This interloper status undoubtedly contributes to an inclination to label mental illness issues as “bad calls.” The “bad call” label thus takes on two potential meanings for the police in street mental health scenarios: time drain and question of expertise.

Each time an officer deems a given mental health situation a “bad call,” he makes a claim about police responsibility in managing the street. In these moments, the officer might utilize persuasive rhetorical arguments to protect his own job and the security of the police bureaucracy as a whole. This rhetoric is based in what Mary Douglas, in her study of modern bureaucracy, *How Institutions Think* (1986), describes as Durkheimian sacralization, the process of “placing certain aspects of social life beyond criticism or analysis” (Herzfeld 1992, 67). In this paper, I explore how, in mental health hold situations perceived as dangerous or futile, officers express rhetorical concerns that reflect anxieties of the police bureaucracy as a whole about the boundaries of police responsibility in managing street-based mental illness. These displays are rhetorical in that they are intended to persuade others, whether DMH social workers or family members of the mentally ill, to acquiesce to a given officer’s decision in a mental health hold scenario. These decisions can be loosely, if at all, based on legal standards.

The Political Economy of Mental Illness

Police decision making in cases of mental illness takes place within an influential political economic context. While this context does not dictate police action per se, it is crucial in

both perpetuating states of severe mental illness and providing police and social workers with few good options to turn to when deciding whether and where to send disruptive, acutely, and severely mentally ill individuals for psychiatric assessment. As noted by Paul Brodwin (2013, 1),

In the United States, people who are poor, alienated from their families, and dependent on public services face enormous obstacles to decent outpatient care. They rely on a fragmented collection of emergency rooms, crisis centers, and case management programs. The pace of work in these settings is rushed, the resources inadequate, and the possibility of failure ever present. [...] The declining core of older North American cities is a magnet for people dependent on public services, including the chronically mentally ill. Such neighborhoods resemble an asylum without walls – the tragic and unintended outcome of deinstitutionalization [...]. The neighborhoods concentrate people who are alienated from dominant norms of productivity and self-control. Inevitably, some of them spend time in shelters, where the impermanence and grinding uncertainty magnify their despair. They cycle through prisons and emerge with stigmatizing legal records that make housing and employment even harder to find. Some become homeless and drift to the marginal zones of the city, sites of violence and social extrusion.

With deinstitutionalization, the total number of psychiatric inpatient beds has dropped from a “high point of 559,000 in 1955 to 193,000 in 1978, 110,000 in 1985, and 80,000 in 2002” (Brodwin 2013, 32). Beyond this precipitous drop, there has been no concerted, adequately funded, nation-wide effort to develop alternative one-stop centers for mental health and basic needs (food, clothing, shelter, transportation) support for the severely mentally ill (Estroff 1981; Grob 1996; Grob 2014; Grob and Goldman 2006; Rhodes 1995). Thus, beginning in the 1960s,

“The rising cohort of young people with severe psychotic disorders – which usually begin in people’s late teens to early thirties – entered into a new array of treatment options. For the first time in nearly a century, people now experienced the onset of severe disorder while remaining outside of long-term institutional control. These young adults established a new pattern in their use of psychiatric services that continues until today: a “revolving door” of inpatient stays, stabilization via medication, discharge to the community, resumption of isolated and disorganized lives, and subsequent rehospitalization. [...] The severity of illness, the fragmentation of services, and the realities of urban poverty (including

easy access to alcohol and street drugs) make it enormously difficult for people to recover fully or to establish independent lives outside the welfare, medical, and criminal justice systems. [...] For the first half of the twentieth century, housing, food, daily occupations, medical and psychiatric treatment, and even social identity came bundled together for patients, who lived in self-contained state hospitals with populations as large as 11,000. As states scaled back these custodial institutions and shifted the costs to federal programs, the de facto responsibility for ex-patients fell onto a fragmented network of psychiatrists, police, judges, and social workers. In the current landscape, many different authorities target the needs of people with severe mental illness, but in an uncoordinated fashion. [...] Although state and county mental hospitals continue to exist, they now offer short-term stabilization or serve as the last resort for the most treatment-resistant and difficult-to-place individuals. In stark contrast to the earlier era of total institutions, people with severe mental illness are scattered throughout society, and no single organization or profession accepts responsibility for their lives (Brodwin 2013, 33).

Thus, in the United States, although 1 in 25 adults (10 million) experience serious mental illness in a given year, approximately 37% receive no treatment (National Institute of Mental Health). On a single night in 2017, 553,742 people in the United States were homeless, including 76,501 in New York City and 55,188 in Los Angeles County (The U.S. Department of Housing and Urban Development, Office of Community Planning and Development). An estimated 26% of homeless individuals are severely mentally ill (National Coalition for the Homeless). This macro perspective of the mental health system is important to keep in mind when considering micro, day-to-day interactions on the street between police, social workers, and the mentally ill.

Discretionary Policing

In his book *Sidewalk*, sociologist Mitchell Duneier (1999, 255) examines the lives of vendors selling wares on the streets of New York City in the 1990s. In the classic sociological text *Street Corner Society*, William Foote Whyte (1993, 138) describes the racketeering activities of men living in an Italian slum on the North End of Boston in the 1930s. In both cases, the authors pay close attention to the ways in which the police selectively manage street life by collectively defining boundaries and punishing those who cross the line. I use this selective

management, the differential interpretation and enforcement of codified legal standards based on context, as the definition of discretion in this paper.

In regards to street-based mental illness policing, I want to know what individual police officers do with their discretionary freedom. Specifically, how they manage both acutely mentally ill individuals and DMH social workers by defining boundaries for what counts as aberrant behavior that requires psychiatric hospital assessment. As the four ethnographic cases to follow will show, the implications of discretionary boundary-setting between police and social workers ultimately dictate which mentally ill individuals receive this assessment.

The Tripartite Structure of Mental Health Policing

Mental health policing can essentially be understood as a choice between three options. In any given interaction with a mentally ill person in the community, the police can arrest the individual, use physically or verbally coercive means to send the individual to the hospital for psychiatric assessment, or choose not to act. In this paper, I will focus on the non-carceral options, specifically the police choice between hospital assessment and inaction. I will explore how and when police decide to assist DMH social workers in sending the mentally ill to the hospital for assessment. I want to examine the ways in which police discretion in interactions with the mentally ill is reflected in the rhetorical forms of concern, the persuasive arguments that they make around liability, danger, and futility that attempt to informally and at times extra-legally establish boundaries for police responsibility in cases of street-based mental illness.

ETHNOGRAPHIC CASES

The following four cases are presented as a set of two contrasts in order to give the reader a sense for the ways in which police bureaucratic anxieties, as expressed through individual

officer concerns of liability, danger, and futility in the context of mental health “bad calls,” influence whether or not a mentally ill individual receives psychiatric assessment. As previously noted, these anxieties are expressed in a political economic context defined by desperate safety net underfunding for mental health care and treatment. These anxieties also occur in the context of influential, socio-political movements of the 2010s, including Black Lives Matter, which have brought increased public scrutiny to street-based police actions. While not the outright focus of this paper, it is crucial to keep these perspectives in mind when reading the cases.

I have chosen to first present each case in its entirety, with little analysis, in order to provide the reader with context and to capture officer concerns in the moment. Above all, I want to avoid oversimplifying the complex interactions between police, social workers, and mentally ill individuals and family members that occur in flash hospitalization scenarios. The alternation between case vignettes and theoretical analysis is my attempt at a compromise.

For each case, original field notes have been edited for cohesiveness and brevity. All quotations were documented in the field and are presented as closely as possible to verbatim accounts. Tape recording was not utilized in composing original field notes due to patient and provider privacy requirements. All personal and place names have been anonymized.

The cases all take place in one of the largest metropolitan areas in the United States. Three different agencies are represented: an urban sheriff’s department (Case 1), a city police department (Case 2), and a suburban police department (Cases 3 and 4). All three departments work under the same state penal code. Per law, licensed clinicians or police officers may deem a mentally ill individual a danger to self/others and/or gravely disabled and take, or cause to be taken, the individual to the hospital for psychiatric assessment.

In each of the four cases, a licensed DMH social worker has completed the hold paperwork required to send a severely mentally ill patient to the hospital for assessment by a psychiatrist. The social worker has called the police for assistance in ensuring safe patient transportation. Cases 1 and 2 describe interactions with mentally ill individuals in the community, while Cases 3 and 4 portray interactions in private residences. In Cases 2 and 4, police assistance plays a key role in ensuring that the mentally ill individual is transported to the hospital. In Cases 1 and 3, police decision not to act leads to the mentally ill individual being left in their community or home. The four cases are drawn from 15 ethnographic observations of mental health hold interactions between police and mentally ill individuals. Of these 15 interactions, the police chose not to assist, physically or otherwise, in ensuring that the mentally ill individual was transported to the hospital for psychiatric assessment in 3 cases. I chose the four specific cases presented in this study both to portray the important police logics at play when choosing not to assist and also to provide the reader with illustrative instances of police assistance.

At first glance, the four cases are strikingly heterogeneous. They contain a variety of actors in diverse circumstances. Confusion abounds on all sides. Strict adherence to the law is not the norm. On closer inspection, however, each case has core similarities: a severely mentally ill individual experiences an acute psychotic episode, is identified by a judge or social worker as needing psychiatric assessment, and is placed on a mental health hold. The outreach social worker attempts to safely transport the mentally ill individual to the hospital for psychiatric assessment. To do so, the social worker calls the police, “the main institution to which the state delegates the legitimate use of force” (Bittner 1967; Fassin 2013, 18). Upon arriving at the scene,

the police decide whether or not to assist the social workers, to use physical or verbal means to ensure that the mentally ill individual is transported to the hospital.

Case 1: Running

Maria, Kathy, and I arrive at the library, a hulking modern building set back in a block-sized park and surrounded by densely populated streets. Maria and Kathy are social workers with the county Department of Mental Health (DMH). Their job involves identifying frequent users of mental health services in the county and linking these individuals to clinic and case management services. We exit our car and walk over to say hello to Mark, Susan, and Sheriff Johnson. Mark and Susan are also DMH social workers. Sheriff Johnson is an officer with the local sheriff's department. He is a muscular African American man of average height. He wears plain clothes, including a tight-fitting green t-shirt, baggy gray commando trousers, sunglasses, and a leather sheriff's badge on a metal chain around his neck. He has received mental health training beyond that provided in the standard law enforcement curriculum and has been designated a mental health specialist by the sheriff's department.

Mark informs us that he and Kathy saw Iris, a severely mentally ill woman, run through traffic, narrowly missing being hit by a car a few hours ago. They point to the park surrounding the library as Iris's last known location. The social work team discusses the case and agrees that Iris should be placed on a hold per her previous mental health history, which includes numerous psychotic episodes and subsequent hospitalizations, and Mark and Susan's account of Iris putting herself and others in danger by running through traffic. Mark calls an ambulance for transport.

The social workers agree to split into pairs between two cars in order to locate Iris in preparation for the ambulance's arrival. They look to Sheriff Johnson and ask for his assistance. They ask Johnson to "go hands on," or physically engage Iris, if needed in order to place her in

the ambulance. Johnson mentions that he does not want to “get into a battle” with Iris that could be witnessed by community members around the library. Dressed in plain clothes, he is aware of his surroundings and does not want to lose community trust and/or be accused of police abuse and potentially risk his job. He notes that he is currently the only law enforcement officer at the scene and needs to call the city police for backup should the situation get out of hand. Johnson states preemptively that he “works for the community, which does not necessarily include the Department of Mental Health.” Ultimately, he agrees to remain on standby and call additional police backup should the social work team locate Iris.

Mark, Kathy, and I jump back into our DMH county car and hit the road. We circle around the library park and quickly spot Iris. She is a thin African American woman in her early 20’s who wears flip-flops and a long, tattered dress that hangs precariously off one of her shoulders. She walks down the middle of a quiet neighborhood street and speaks to herself, holding her head in her hands. Iris exits the side street and crosses a busy, four-way intersection through traffic and against a red light. We wait for the light to turn and slowly trail behind her as she walks down another neighborhood street. Iris then walks into the pump area of a corner gas station and sits down on an island between pumps. Mark calls Sheriff Johnson and provides him with Iris’ current location

Ten minutes later, Sheriff Johnson pulls into the gas station in an unmarked sedan. A uniformed officer from the city police department follows in a squad car. Sheriff Johnson and the city police officer exit their respective vehicles and approach Iris. Iris turns, spots the pair, jumps up, and sprints across the gas station parking lot. She then runs through a four-way, lighted intersection and disappears down the street. Neither Sheriff Johnson nor the city police officer

attempt to detain Iris as she runs away. The city police officer returns to his squad car and departs without saying a word.

Mark, Kathy, Maria, Susan, and I exit our respective cars and approach Sheriff Johnson. Johnson states, “You guys are going to have to come back another time. I do not see the hold happening today.” He explains that he is “here to assist,” but not to “do DMH’s bidding. We aren’t just going to detain and carry her. We can assist, but we can’t [necessarily] assist DMH.” “To make it a more legitimate law enforcement presence,” Johnson also needs city police support. He continues, “That way, the community doesn’t think we are going to beat up this girl. She’s always a flight risk.”

Despite Sheriff Johnson’s unwillingness to use force, he and the social work team ultimately agree to relocate Iris and attempt to peacefully coax her into the ambulance. We quickly find Iris again. Sheriff Johnson slowly approaches her in his car. She again runs down the street, this time in the direction of the library.

We drive to the library and park. The ambulance that Mark requested earlier arrives and parks nearby. Sheriff Johnson pulls up and exits his car. Twenty yards ahead, Iris walks down the sidewalk. Johnson again tries to approach her on foot. She turns, notices him, and sprints into the library park.

Two young women approach. They are Iris’s neighbors and note that they speak to Iris on occasion. They know that she needs mental health assistance and ask whether it is ok if they enter the park and attempt to talk to Iris. Sheriff Johnson and the social workers thank the women and agree that this is a good idea. The women enter the park and return shortly. They were unable to speak to Iris as she also ran away from them.

Sheriff Johnson and the social workers convene and debrief the case. Mark informs the ambulance drivers that the hold will not be happening today and that they are free to leave. Johnson lays out the case for why he is not able to help the social work team today. “You see how she just ran? And how the other [local] police officer just left? You see how the police backed off? By myself, she’s just a runner. Then you get people watching and wanting to videotape.” He continues, “The Department of Mental Health knows we are law enforcement. But they don’t know what we can and can’t do. We know she [Iris] has to go. But, DMH doesn’t know what else we [the police] are responsible for. If she came up to me, I would have to fight her. I can’t get in a fight with a mentally ill person. We can’t get in foot pursuits – it is against our policy. 100% of the time we won’t chase.” Johnson thinks for second, checks himself, and continues, “I don’t have a problem grabbing her if she is right here, but if she runs away from me into the streets and we chase and a truck hits her, I’m at fault. We go to court and they blame me and I am in trouble. I have a kid. I don’t want to do something crazy and get fired.” It is “better to come back another day” and try to place Iris on a hold in the most nonviolent way possible. “We tried here. We called [a local city police officer] and tried to talk to her,” he laments.

Sheriff Johnson then provides a partial solution to the problem. He calmly lectures to the group, “I’m here to help with mental health. Mental health is one of those things that will never end.” He explains that standard law enforcement officers do not like to be told what to do. The police view social workers as civilians trying to help the mentally ill. The police also view mentally ill clients as DMH’s responsibility. To bridge this gap, DMH social workers must clearly explain why they want to place a given client on a hold and why they need police assistance to facilitate the process. The police then need to make a case-by-case determination whether to proceed given the circumstances.

Sheriff Johnson also informs the social workers that standard police deputies “don’t know” much about mental health. “I know they don’t know” about how best to work with DMH, he says. Johnson encourages the social workers to explain the hold process to and get to know deputies in order to form working relationships.

Johnson ends with a final thought. He describes how the police work with the mentally ill every day. Many of these individuals have been discharged prematurely from hospitals around the county. Those who do not have family or friends to provide help and shelter end up roaming the streets without care. Johnson comments, “Psychiatrists are not out in the streets like us.” He bemoans the separate functioning of the police and hospitals and reasons that if physicians regularly witnessed the state of mental illness on the street, they would be less likely to prematurely discharge patients.

Case 2: Kidnapping

As a contrast to Case 1, I introduce a second case in which a mentally ill individual runs through traffic and places herself and others in danger. Unlike Sheriff Johnson from Case 1, the city police officers in Case 2 go hands on and assist in transporting the mentally ill patient to an urgent care center for psychiatric assessment.

I ride with DMH social workers Jessica and Tom to a homeless drop-in center. We are attempting to locate Julia, a middle-aged woman with a history of psychosis who walked through traffic earlier in the morning. Sam, a drop-in center employee, comes out to the sidewalk to greet Jessica, Tom, and me as we exit our car. Sam explains that he recently witnessed Julia walk into the street. He called the DMH social workers out of fear for Julia’s safety. He states, “She [Julia] walked out into traffic this morning right here [points to the busy street]. She didn’t look either way and just walked into the street as if she didn’t know there were cars there.” Sam reports that

Julia also threatened to kill him three weeks ago. He dismissed the threat at the time and emphasizes that this was not the primary reason for his contacting DMH to assess Julia today. He notes that Julia is currently taking a shower at the drop-in center.

Sam shows Jessica, Tom, and me to an office cubicle where we wait for Julia to finish her shower and for the police to arrive. Twenty minutes later, Sam stops by to report that Julia left the drop-in center after her shower. However, he just received a call from a co-worker who runs an affiliated food kitchen nearby with word that Julia showed up at the kitchen for lunch.

We follow Sam out of the drop-in center and walk the few blocks to the kitchen. Once there, Sam points out Julia. Jessica enters the kitchen and speaks to Julia. Jessica returns five minutes later and reports that Julia is exhibiting erratic, disoriented behavior. Jessica and Tom agree that, given Julia's current state and the fact that Julia placed herself and others in danger by walking into traffic earlier in the morning, they will write a mental health hold and send Julia to the hospital for psychiatric assessment. Given Julia's past threats and potential for violent behavior, Jessica and Tom also agree to request a police presence during the hold in case the situation turns violent. Tom steps away and calls the police. Tom also completes the hold paperwork required to send Julia to the hospital for psychiatric assessment. Finally, he calls an ambulance company and schedules ambulance transport for Julia. The ambulance is scheduled to arrive in one hour.

Fifteen minutes later, a police squad car pulls into the alleyway outside the kitchen. Two officers, both white men in standard dark navy city police uniforms, exit the car. Officer Kleinman, a tall, bald, muscular man in his late 30s introduces himself first. Officer Reardon, a young, tall, thin man with a buzzed haircut follows. Reardon is a deputy in training. Kleinman is in charge. Jessica informs the officers about Julia's case. Kleinman asks whether Julia has a

violent history. Tom and Jessica confirm that Julia has escalated and become violent in the past. They also relay the violent threats that Julia made towards Sam three weeks ago.

Kleinman comments that he is more than willing to help out with mental health cases. However, he asks Jessica and Tom to again confirm that Julia is not currently violent or running into traffic - Julia is being sent to the hospital due to reported dangerous behavior (walking through traffic) and her own violent psychiatric history; the police are present in order to keep Julia from leaving and to detain her if she tries. Kleinman notes that he needs to document these exact reasons in his incident report.

Kleinman then reasons that technically, “private organizations writing holds” is not something that the police should be regularly called to deal with. Jessica counters that she and Tom work for the Department of Mental Health, a government organization. Kleinman returns to his squad car, calls his sergeant, and walks back to our group. He relays the sergeant’s message, noting that holds of this sort are DMH’s business. If the client is not violent at the current time, the police do not need to be present. If the situation escalates, the police will get involved.

Kleinman then notes that he would like to see Julia in person before making a decision as to whether to assist with the hold. He emphasizes that he does not want the situation to end in a use of force. He enters the kitchen along with Reardon. Ten minutes later, Kleinman and Reardon exit leading a handcuffed Julia, a middle-aged Latina woman wearing a loose red t-shirt and worn blue jeans. Kleinman places Julia in the back seat of the squad car. Kleinman agrees that Julia needs to be taken to an urgent care for assessment. However, he remarks that his department will not be “moving bodies” for DMH in the future. Per his sergeant, cases like this fall under DMH’s purview.

Jessica hands Reardon the hold paperwork and says goodbye. As we turn to leave, Kleinman asks that we meet him at the urgent care. He informs us that, since Julia is not currently violent, she is free to walk away if she chooses without police stopping her. Jessica and Tom agree to meet at the urgent care. Kleinman and Reardon return to their squad car and depart.

On the drive to the urgent care, I ask Jessica and Tom whether this was a typical interaction with the police. Tom comments that Julia is being transported to the urgent care, which is what needed to happen. However, he notes that no one asked Kleinman and Reardon to personally do the transport. Tom had made the ambulance reservation for this reason. Jessica is confused as to why the DMH social workers need to accompany the police to the urgent care. She claims that if the police have the hold paperwork in hand, they can simply drop the client off at the urgent care, present the paperwork, and leave. The physician at the urgent care will then assess the mentally ill individual and decide whether to hospitalize them.

Jessica, Tom, and I arrive at the urgent care. We enter the intake room, a small, sparsely furnished space with two plastic waiting chairs, a security desk, and a set of lockers containing patients' valuables. The police arrive and lead Julia inside. Reardon exchanges Julia's police handcuffs with a pair provided by the urgent care security guard. Julia stares across the room and mumbles incoherently, occasionally raising her voice. The security guard processes the intake, gathers Julia's belongings (a pair of glasses and a few sheets of paper) into a paper bag, and places a call to the intake nurse. Kleinman informs Julia that she is not under arrest. Julia notes that she is happy to hear this, but is worried about parole issues, and Kleinman encourages her not to worry. Tom and Jessica thank Kleinman for his help.

Case 3: Washing Hands

Unlike Cases 1 and 2, Case 3 occurs in a private residence. The officers involved in Case 3 work for a suburban police department located in the same county as the sheriff (Case 1) and city police (Case 2).

Mark (DMH social worker) and I arrive in Greenville and slowly drive by Derek's apartment. The unit is located on the second floor of a two-story, low-slung apartment complex that is the size of a large family home. The owner of the complex sits on the second story walkway with his pit bull dog and watches as we pull into the nearby parking lot. We get out of our cars and meet Paul, another DMH social worker.

Paul wants to make sure that Derek is in the apartment before initiating the hold and calling the ambulance and police to the scene. We climb the stairs to the second floor and introduce ourselves to the apartment complex owner. The owner leads us down the walkway to Derek's apartment door. Paul informs the owner that the DMH social work team needs to see Derek in order to inform him of the mental health hold. The owner nods, jiggles his universal key in the lock, and pops Derek's door open.

Paul walks through the living room toward the back of the apartment and calls Derek's name. The bedroom door opens and a tall, gangly silhouette appears. Paul approaches and calmly states, "Derek. Do you remember me? I am Paul with the Department of Mental Health."

Derek, a tall, thin African American man wearing a grey t-shirt, jeans, and black plastic eyeglasses responds, "I remember you. I do not want services. I am fine. Please leave my apartment. I have done nothing wrong."

Paul continues, "Derek, I am here to let you know that you have been placed on a hold from the judge for not showing up to court. Do you understand what I am saying?"

Derek replies, “I do not need services. Please leave my apartment now. I am fine.” Paul calmly asks whether there are any food or goods that the team can provide. Derek declines the offer and again states that he does not want services and would like to be left alone. Paul, Mark, and I leave the apartment.

Once outside, Paul calls the ambulance service. Within 15 minutes, Mark flags the ambulance down on the street. Paul recognizes one of the ambulance attendants from a psychiatric hold in Greenville earlier in the week. Since he knows the mental health hold drill, the attendant only needs a small amount of information about Derek’s diagnosis and the requested drop-off hospital location. He begins to unpack his equipment, including a gurney with Velcro restraints, in preparation for the hold.

Paul also calls the Greenville Police Department. Five minutes later, Officer Ramos arrives and collects information about the case from Paul. Within minutes, three more officers arrive. The crowd begins to draw extended stares from motorists and pedestrian passerby. For the next twenty minutes, the officers ask about details of the case. Ramos summarizes what she knows so far, sharing Derek’s height and weight. The officers are interested in these measurables in the event that physical confrontation with Derek becomes necessary.

Lieutenant Adams and the mental health outreach nurse arrive in an unmarked car. Mark turns to me and mentions that Adams and the nurse comprise the Greenville Police mental health team. Their main job involves “talking down” acutely mentally ill patients in order to avoid the use of police force in mental health hold scenarios. Adams gregariously shakes Paul’s hand. Paul shares the hold and court paperwork with Adams and describes Derek’s condition. Adams is happy to help with the hold. One of the officers questions whether the entire team is needed for

the hold. Adams responds, “If you have it, the show of force is always the way to go! Let’s do this!”

The five officers, nurse, Paul, Mark, and I climb the stairs and enter Derek’s apartment. Paul leads the crowd and approaches Derek’s bedroom door. Derek states, “I do not want services. Please leave my apartment.”

After hearing Derek repeat this statement a few times, one of the officers steps past Paul, flicks on the light in Derek’s bedroom, and firmly states, “Hey buddy, it’s time to go.” He grabs Derek with a rubber-gloved hand and leads Derek to the front door.

Derek proclaims, “I am Moses. You people are not God. The court judge is not God. God is in the Bible. Don’t you read the Bible? Don’t you believe?” The officers quickly escort Derek down the stairs and into the small courtyard in front of the apartment complex, where the ambulance workers stand with the gurney. Derek begins to realize what is happening. He does not resist, fight, or attempt to run. However, he lashes out verbally at Paul, calling him a “snake” who tricked him into treatment. Paul responds that he is only following court orders. Derek continues to explain that God is the judge, not Paul or the doctors at the hospital. Three officers surround Derek and strap him to the gurney.

Lieutenant Adams addresses Derek, “I read the Bible. Do you know [of Pontius Pilate]? Sometimes you need to be [Pilate] and wash your hands of the situation. Do you understand me? You are [Pontius Pilate]. Think about that.” Derek continues to yell as he is wheeled off and placed in the ambulance.

The officers debrief and celebrate the efficient and non-violent hold. They take pride in going “one-for-one.” They tell the DMH social work team that they will be happy to assist with holds in the future.

Case 4: Hiding Out

I introduce a second case in which a mentally ill individual has locked himself in a private residence. The officers involved in both Cases 3 and 4 all come from the suburban Greenville Police Department. Unlike the officers in Case 3, who entered the apartment and went hands on with a nonviolent mentally ill individual, the officers in Case 4 do not engage a mentally ill individual who has a violent history.

Mark and I jump into the DMH county car and head toward Greenville, a large suburb on the outskirts of the metro area. Mark and Paul, both DMH outreach social workers, will attempt to place a hold on Zach. Last week, Zach was placed on a hold and brought to the hospital. The attending psychiatrists deemed him not dangerous or gravely disabled and released him. Unfortunately, this early release meant that Zach did not make it to his scheduled mental health court hearing.

Mark summarizes the previous hold. He recalls that Zach, “held us [DMH social workers, ambulance workers, and police officers] up for 20 minutes in this big garage. He ended up getting on the gurney and going on his own. The ambulance workers were willing to go hands on and the Greenville police provided a good show of force [presenting themselves as a large, imposing group and encouraging Zach to cooperate].” Mark also describes how Zach often runs around his neighborhood, yelling racial obscenities at strangers and shooting pellet guns at neighbors’ homes.

We arrive in Greenville and find Paul leaning against his parked car. Paul points to the ambulance idling a block down the street. He explains that Zach’s mother has a restraining order against Zach. However, she allows Zach to sleep on her porch and even enter her home. She

repeatedly calls 911 due to Zach's disruptive behavior at home and in the community, but is unwilling to testify against Zach for physical abuse or violating the restraining order.

Judge Lee of the county mental health court wants to see Zach in court in order to administer a psychiatric assessment and develop a treatment plan. Lee knows that one of the only ways to ensure that Zach will present to court is to place him on a psychiatric hold. If Zach is hospitalized at the time of his scheduled court appointment, the hospital will transport him to the appointment.

Two squad cars pull up. Sergeant Bradley, a heavy-set, African American man in his late 40s with short, balding hair and dark sunglasses steps out from one car. Officer O'Hare, a white, middle-aged woman wearing small, circular sunglasses emerges from the other car. As Bradley introduces himself to Paul and Mark, four more squad cars pull up. Officer Ramos steps from one car and joins our group in discussion. The rest of the officers idle in their cars. Sergeant Bradley states, "We were just out here last week and had to forcefully detain Zach and place him on a hold. We did it with your team. The mom calls 911 all the time and we come out here often. What are you guys looking to do today?" Paul replies that, despite the hold last week, psychiatrists at the hospital deemed Zach not gravely disabled or dangerous and allowed him to leave. Bradley sighs, "Well, how many times are we going to do this? If it made no difference last week, why are we going to send him to the hospital again?" Paul explains that Zach needs to be hospitalized due to his continued disruptive and violent behavior at home and in the neighborhood. He also emphasizes Judge Lee's need to see Zach in court.

It is hard to ignore the tension building between Bradley and Paul. Bradley seems on edge, almost annoyed by the call. He states, "You know, it is really hot out here today. We have a protest going on in town and the watch commander is over there. I don't know what you guys

want us to do here. We have bigger things going on today. Again I said that we are here [with Zach] all the time. I don't know what else we can do today.”

Bradley, O'Hare, Paul, and Mark turn and watch as, across the street from the idling police cars, Zach, an obese white man wearing a loose-fitting t-shirt and long, baggy athletic shorts exits his mother's home and sits down on a chair on the porch. He appears to be tying his shoes. After a minute, he stands up, waves to us, and goes back inside the home. Bradley turns to Paul and states, “What you guys couldn't even go and talk to him before we came?”

Paul replies, “We didn't want to scare him off before you all arrived. He has been known to run.”

Bradley, O'Hare, Mark, Paul, and I approach the house. We hear Patricia, Zach's mother, shouting inside. Suddenly, she stumbles backwards through the front door. Paul steps onto the porch to steady her. As he does so, a variety of pill bottles come flying out of the front door and collect on the porch. Patricia gasps, “He [Zach] grabbed me! I bruise so easily. I think I have a bruise on my arm!”

Bradley and O'Hare stand ten feet back in the middle of the front lawn. Patricia pleads her case. She would like Zach to be hospitalized and taken to court. Zach continues to throw pill bottles out of the door. He then slams and locks the door from the inside.

Bradley turns to Paul, stating, “We can't violate the Constitution for this. If we were to open a locked door, we would be violating the Fourth Amendment. I'm sorry, but I don't think we can help you today.”

Paul pleads, “But last week, you all went hands-on with him [Zach] for a hold. You entered the home and took him down [tackled him] in the kitchen.”

“Yes, I know,” responds Bradley. “We can’t risk an officer injury for this though. Opening a locked door, even if mom has the keys, risking officer injury, possibly having the guy come at us with a weapon, and the risk of us having to shoot him for coming at an officer. We can’t have that. It would be all over the news. These things have happened and we don’t want to be there.”

Bradley nods to Ramos, who gathers up the rest of the idling police officers and leaves. Intent on making his case, Paul continues to engage Bradley. For the next half hour, Bradley, O’Hare, Paul, Mark, and Patricia debate the case. Bradley stands by his argument that the police should not be involved. He continues to stress that entering the home with Zach locked inside would be a violation of the Fourth Amendment. He also highlights the fact that Patricia, herself, is violating the restraining order, since she allowed Zach into her home.

To counter, Paul summarizes the instances in which Greenville police officers have assisted DMH social workers in placing holds in the past. For example, during the hold procedure with Derek (Case 3), the apartment complex owner unlocked Derek’s door without Derek’s permission and allowed the DMH social workers and police inside. Paul reasons that, since Patricia owns her home, why is this case any different with Zach behind the locked door.

For her part, Patricia is unwilling to press criminal charges against Zach and refuses to drop the restraining order. She “knows that [she is] co-dependent, but can’t stop helping Zach.” She wants Zach to be assessed by a judge and transferred to a treatment facility. “He runs around the neighborhood and harasses the neighbors. He yells racial insults at everyone. I don’t know where he learned these things. He wasn’t raised like that,” she states.

Hearing this, Bradley comments, “We all deal with racial insults. Like I’m sure he (pointing to Paul, who is African American), has been called a nigger plenty of times in his life. And those guys (pointing to the two Latino ambulance drivers), are called things all the time.”

Paul eyes Bradley, shakes his head, and states “I have never been called that word in my life.” Paul then asks to speak to Bradley’s watch commander.

Bradley points to himself and states that the “supervisor” is here. Paul again insists on speaking to the commander. Bradley stresses that the watch commander is “tied up with a march going on in town.” Paul asks for the commander’s phone number. Bradley will not give Paul the number but agrees to call the commander himself. He steps away to talk and returns after 10 minutes. He relays that the watch commander agrees that no police will be involved with Zach’s case today as the risk for injury is too high. Also, since a hold was just performed last week on Zach (who was subsequently released from the hospital), there is no clear reason to engage again now.

O’Hare turns to Patricia and comments, “You need to stop thinking with your heart and start thinking with your head. I am sorry to be the one to tell you this.”

Bradley points to the ambulance team and states, “Next time [DMH] comes out to do one of these holds, be sure to get an ambulance team that is able to go hands on.” The ambulance workers reply that they are able to grab patients, but that they have only been trained to do so in the open. Doing so in a closed, indoor space is very dangerous.

Paul continues to question Bradley, saying, “But Officer Ramos went hands on [with Zach] last week.”

Bradley counters, “I can’t believe Ramos did that.” He continues, “We can’t force entry. He could come at us with a knife and then we would have to kill him. How many times do we have to do this?”

As a final attempt, Paul hands Bradley the hold paperwork, signed and stamped by Judge Lee. Bradley skims the sheet, his finger following the words line by line. After a minute, Bradley looks at Paul and shakes his head. Bradley states, “Yeah, this doesn’t give us permission to go through the locked door.”

Frustrated, Paul asks, “Well what kind of hold would give you permission?”

Bradley replies, “I don’t know. The courts have to work that out. If it explicitly stated that we could go through a locked door, it would be one thing, but it doesn’t say that. Maybe they can change the hold paperwork.”

Lieutenant Adams and a DMH mental health outreach nurse arrive on the scene. The pair work as a special unit of the Greenville Police Department tasked with handling mental health cases. It is not clear why Adams, the department’s mental health specialist, did not arrive earlier to deal with this case. Bradley and O’Hare say goodbye, head to their squad cars, and drive away.

Paul summarizes the situation for Adams and the nurse. Adams strokes his chin and stares at the sky. “Zach grabbed mom and pushed her out of the door? Oh, that changes things,” he muses. Adams thinks the police could have found a way to detain Zach had they wanted to.

Paul comments, “Yeah, we have been in the same situation in the past. Remember with Derek (Case 3) a few weeks ago? The apartment complex owner had a key and let us into Derek’s locked apartment. It’s hard to think how this situation with Zach is any different when his mom has the keys and owns the house.”

Adams nods and continues, “Bradley would be mad at me if I got involved here. As he was saying, it is hot out here today with the protest downtown. He gave the call that Zach wasn’t a top priority given how things look out there today. He’s not going to come back and get involved.”

Patricia stomps her foot and yells, “I can’t put up with this anymore. You all aren’t going to do anything? I am just sick of this. Zach shoots pellet guns at neighbors’ homes. He runs all over the neighborhood and terrorizes people. And you all either don’t answer my calls to 911 or come here and do nothing. I am going to get a massage.” Without saying goodbye, she jumps into her car, peels out of the driveway, and heads down the street.

Adams and Paul smirk and exchange glances. Adams inserts his thumbs into his vest and settles into a wide, relaxed stance. “History turns the screws, guys,” he sighs. “From my perspective, if Patricia had been here and opened the door for us, we could have gone in. But, Sergeant Bradley has already blocked this from going forward today and he’s not going to let it happen on his watch. Use of force requires so much paperwork. And too, there are a bunch of issues with holds and the Americans With Disabilities Act now. A lot of these mental health patients qualify as disabled. If we go hands on with them and something goes wrong, we just get mashed in court.” Adams continues, “Word is out to all around the department by now. Honestly, if you wait until 4pm when Bradley and the watch commander are off, you might have better luck. If they don’t pass on word to the next shift, you might just be able to get Zach. Geez with that history, though? Man. Mom is calling the police all the time. He has been detained and taken to the hospital and nothing has changed. I get that you guys are trying to get him to court so that the Judge can try to come up with a plan. That is the important thing.”

Patricia drives past, pulls into the driveway, and enters her home. Adams and the nurse walk over to Paul, Mark, and me. Mark's cell phone suddenly rings. After a few grunting replies, he hangs up and confirms that Patricia was just on the line. She wanted to inform Mark that she had called 911 again, but that the police refused to come to her home. Apparently, word from Sergeant Bradley not to engage Zach had gotten all the way to the dispatch coordinators.

Surprised, Adams raises his eyebrows and comments, "The beat officers should have come out to a 911 call."

Paul nods and says, "That is a huge liability now. What if something was to happen here inside the home [...] and the officers didn't respond to a direct 911 call?"

"Nothing is going to happen today if this is how it is going," Adams concludes. "It is best that we wrap this up. Call us [Greenville police mental health outreach team] first next time if you are doing [a hold] and we'll try to use our influence." The nurse hands Mark a business card and we head back to our cars.

POLICE RHETORICAL FORMS OF CONCERN

In the above cases, police officers use rhetorical forms of concern, or persuasive arguments, to justify their decisions in mental health hold scenarios. This rhetoric not only reflects the thoughts of individual police officers, but also the anxieties of the police bureaucratic institution as a whole. In this section, I first highlight specific examples of police rhetoric on liability, danger, and futility from Cases 1 and 4, the two cases in which officers chose not physically engage mentally ill individuals in order to ensure transportation to the hospital for psychiatric assessment. I also discuss the broader bureaucratic anxieties that correspond to these rhetorics.

Liability/Danger

In Case 1, Sheriff Johnson provides a variety of arguments for why he does not want to go “hands on” and detain Iris, a visibly psychotic individual who talks to herself and repeatedly runs through car traffic. Johnson comments, “If she came up to me, I would have to fight her. I can’t get into a fight with a mentally ill person.” He continues, “I don’t have a problem grabbing her if she is right here, but if she runs away from me into the streets and we chase and a truck hits her, I’m at fault. We go to court and they blame it on me and I am in trouble. I have a kid. I don’t want to do something crazy and get fired.” Sheriff Johnson also makes repeated references to negative publicity. He is worried about “people watching and wanting to videotape” any physical interaction he might have with Iris. He remarks on how an altercation would be viewed negatively by the community. He claims that he needs city police assistance to not risk community members thinking that he is “going to beat up this girl.”

Johnson’s rhetorical concern, the persuasive argument that he makes for why he cannot physically engage Iris in order to send her to the hospital for psychiatric assessment, is multi-faceted. In saying, “I can’t get into a fight with a mentally ill person,” he justifies not physically engaging Iris by implying that an altercation between a fit, muscular officer and a mentally ill civilian is not safe. However, given the fact that he continues to watch Iris run through traffic and risk her life, Johnson’s decision is not entirely based on a concern for Iris’ safety. His sense of danger also pertains to the risk that such an altercation would have on his own physical safety (running through traffic) and personal security, particularly related to his job and family, should a physical altercation between himself and Iris be witnessed by the public.

Sheriff Johnson’s inaction reflects his place within the police bureaucracy. As noted by Gerald Britain (1981, 11), “The most basic goal of any bureaucrat or bureaucracy is not rational

efficiency, but individual and organization survival.” This is seconded by Michael Lipsky (2010, 18), who notes that, “at the very least, workers have an interest in minimizing the danger and discomforts of the job.” While physically detaining Iris, an acutely mentally ill individual who repeatedly runs through traffic, putting herself and drivers on the road at danger, might seem to be a rational decision, Johnson instead decides to shield both his own job and the greater police bureaucracy from liability. His individual concern reflects a greater anxiety, that of a bureaucracy that does not wish to physically engage with mentally ill individuals in scenarios that could be witnessed by the public and broadcast via the news and social media portraying the police in a bad light.

In Case 4, Sergeant Bradley refuses to enter Patricia’s home in order to detain her son, Zach. Zach has been placed on a psychiatric hold by social workers due to his violent, disruptive behavior and to ensure that he attends a mental health court hearing. Among his justifications for not entering the home, Bradley states, “We can’t risk an officer injury for this though. Opening a locked door, even if mom has the keys, risking officer injury, possibly having the guy come at us with a weapon, and the risk of us having to shoot him for coming at an officer. We can’t have that. It would be all over the news. These things have happened and we don't want to be there.” Later, he bluntly reiterates, “We can’t force entry. He could come at us with a knife and we would have to kill him.” Bradley’s rhetorical concern, his persuasive justification for inaction is two-fold. Not only does he fear for officer’s and Zach’s safety should he enter the home, but also, per his own account, he fears for departmental security should the situation go wrong and be spun by the news media.

Like Sheriff Johnson (Case 1) and Officer Kleinman (Case 2), Sergeant Bradley and Lieutenant Adams (Case 4) are first and foremost bureaucrats, primarily concerned with

protecting their jobs and the credibility of their police organizations. As noted by Herzfeld (1992, 142), “conventional wisdom holds that the only people who possess the power to alter the system are those whose vested interests are best served by perpetuating it [...]. This impression is strongly reinforced by bureaucrats’ persistent refusal to take the slightest initiative or risk.” These interests are clearly evident in Case 4. Indeed, the notion that “‘nothing can be done’ is only another way of saying that the bureaucracy or individual worker does not intend to change priorities. Yet it is often obvious to clients that more could be done if priorities were shifted” (Lipsky 2010, 63). Sergeant Bradley and Lieutenant Adams have the authority to detain Zach, but choose not to do so out of concerns for personal and organizational preservation. This desire for organizational preservation is especially evident in Adams’s refusal to overstep Bradley and detain Zach. Again, the rhetorical concerns expressed by individual police officers reflect broader bureaucratic anxieties related to the media risks and extent of police responsibilities in working with dangerous mentally ill individuals.

Futility

In Case 1, beyond liability and danger, Sheriff Johnson gives a myriad of excuses for why he does not want to and ultimately will not use physical force to place Iris on a hold due to the futility of the case. Sheriff Johnson is not a mental health professional, but he sees little purpose in sending Iris to the hospital only for her to be discharged soon after. He comments, “Mental health is one of those things that will never end.” He also calls out the hospital system for discharging mentally ill patients to the streets and psychiatrists for not being “out in the streets like us [the police].” In this light, Johnson’s lack of action is a comment on the futility of mental health policing. He absolves himself of responsibility for a situation that he cannot change and challenges the medical institution to do its part. Essentially, Johnson attempts to

relieve the police bureaucracy of the worry, the anxiety, of actively participating in a systemic solution to street-based mental illness. Instead, he points to the state of the mental health system and blames it for forcing his hand. He critiques physicians who discharge ill patients to the community and place undue burdens and unsolvable community mental health problems on the police.

In Case 4, Officer Bradley repeatedly frames police action as futile. While discussing Zach's case, he states, "Well, how many times are we going to do this? If it made no difference last week, why are we going to send him to the hospital again." He continues, "Again I said we are here [with Zach] all the time. I don't know what else we can do today." In framing the situation in this way, Bradley not only gives the police credit for past attempts to help Zach but also justifies police inaction and removes police accountability for the case.

To legitimize his decision, Bradley blames the mental health system. From the moment he arrives at the scene, he plays the role of the street-level bureaucrat who works within a "system [that] forces [him] to do things that good people would rather avoid" (Herzfeld 1992, 70). By his account, he is not an evil person who refuses to aid family members and social workers in accessing treatment for severely mentally ill individuals. Instead, he is a hard-working, taxed, government official who tries his best despite the odds, yet ultimately works at the whim of the political economy. Bradley's argument contains an inherent assumption that his interlocutors [Paul, Mark, and Patricia] share this system-blaming tendency. After all, everyone knows that the mental health industry is underfunded, under resourced, and understaffed. As a bureaucrat protecting his job and his department's turf, Bradley appeals to this "ethical alibi of the heartless 'system' [...] in order to explain, justify, [and] excuse [his] seemingly arbitrary actions and decisions." The image of the futile system is "necessary to the self-respect of both

the bureaucrats [Sergeant Bradley and the police] forced to carry out distasteful orders and the clients [family members and social workers] forced to accept their dictates” (Herzfeld 1992, 80). Like that of Sheriff Johnson (Case 1), Bradley’s individual rhetoric reflects the greater anxieties of a police bureaucracy that views itself as a custodial institution for, rather than an active force pushing for systemic solutions within, the domain of street-based mental illness.

CONCLUSION – CARCERAL BUREAUCRATIC BOUNDARIES

Through case-by-case rhetorical concerns about liability, danger, and futility in mental health hold scenarios, police officers reveal deeper, bureaucratic anxieties about the policing of street-based mental illness. I conclude by reasoning that these individual concerns and bureaucratic anxieties serve to maintain police responsibilities within a carceral realm in the context of mental illness policing. I also allude to the importance of paying attention to the social dimensions of police-civilian interactions in these cases.

In review, all police officers in the four cases work under the same state penal code. Per law, licensed clinicians (including DMH social workers) or police officers may deem a mentally ill individual a danger to self/others and/or gravely disabled and take, or cause to be taken, the individual to the hospital for psychiatric assessment. In reality, however, “street-level bureaucrats [the police] make policy” and the legal standard is not always upheld (Lipsky 2010, 13).

What is perceived from the outside, by social workers and family members of the mentally ill, as police discretionary decision-making is really the police maintenance of bureaucratic boundaries, of police responsibilities, over street-based mental illness. Therefore, what might seem to be arbitrary, extra-legal decisions made by individual officers are really the symptoms of a larger institution asked to respond in ways outside of its carceral expertise. What

is perceived as discretion is really an extra-legal definition of boundaries expressed via the rhetorical concerns of individual officers. Hence, acts with no supporting clause in the penal code become reality: police mental health assessment outweighs that of licensed social workers; police unwillingness to use physical force supersedes social worker judgment that a mentally ill person should be placed on a hold; officers only act to deter violence and not to physically assist in transporting mentally ill individuals to the hospital for psychiatric assessments.

For the emergency mental health system to function, beyond routine mental health holds, beyond individual social worker and police actions, there cannot be “bad calls.” There cannot be mentally ill individuals who meet penal code criteria for psychiatric assessment yet are not transported to the hospital due to bureaucratic concerns over time commitments, priorities, or lack of expertise. The “bad call” cannot be used as a means to stake claims over institutional responsibilities in managing street-based mental illness.

Moving past the notion of the “bad call” would entail individual police officers speaking, and ultimately acting, in non-carceral ways. In Case 1, Sheriff Johnson would work with the social work team to ensure that Iris, a mentally ill individual who repeatedly runs through street traffic and places herself and others in danger, would be sent to the hospital for psychiatric assessment. In Case 4, Sergeant Bradley and Lieutenant Adams would find a way to remove Zach, a violent mentally ill individual, from his mother’s home and send him to a hospital for psychiatric assessment. Even in Case 2, Officers Reardon and Kleinman would focus not on their personal time commitments and priorities, but on guaranteeing that Julia, a psychotic individual who runs through traffic, is safely sent to the hospital for psychiatric assessment. Ideally, none of these cases would involve police carceral expertise. The mentally ill individuals involved would not be arrested or sent to jail. The act of assisting, physically or otherwise, in transporting these

individuals to the hospital for psychiatric assessment would be viewed as the responsibility of the police, an act within their bureaucratic boundaries.

While the four cases included in this analysis are specific to mental health holds, the need to eliminate of the “bad call” label applies to mental illness policing as a whole. This would entail the police truly adopting non-carceral responsibilities in dealing with mental illness. In this world, individual police officers would not need to argue that danger, liability, and futility exculpate them from ensuring that acutely mentally ill individuals are transported to the hospital for assessment. The police bureaucracy would not need to feel anxious when asked to take on extra-carceral responsibilities. The police would truly open their bureaucratic boundaries and shoulder extra-carceral responsibilities side-by-side with social workers, family members, physicians, and others involved in caring for and treating mental illness. Case 3 provides an example for how this might work.

While not explicitly explored in this paper, social factors including race, class, and gender dynamics influence police interactions with civilians and must be accounted for in any discussion of police extra-carceral bureaucratic responsibilities in managing street-based mental illness. In the wake of the Black Lives Matter movement and visceral cases such as that of Eric Garner, an African American man suspected of illegally selling single cigarettes who was placed in a headlock by a police officer, repeatedly stated “I can’t breathe,” lost consciousness, and later died at a hospital, these social factors are at the forefront of officers’ and civilians’ minds in street-based interactions (Goldstein and Schweber 2014). As shown in Case 1, Sheriff Johnson chose not to physically engage or chase Iris, an acutely mentally ill African American woman wearing tattered clothes and repeatedly running through busy city streets. Johnson justified his inaction by stating that he did not want to “get into a battle” with Iris that could be videotaped

and witnessed by community members. He worried that physically engaging Iris in public could lead to him losing trust with the community, and even losing of his job over fallout from accusations of police abuse. Iris, an acutely psychotic individual, did not receive a psychiatric assessment due partly to this logic. Society-wide conversations about police use of force and race, class, and gender dynamics in police-civilian interactions are thus seen to penetrate the policing of street-based mental illness.

The mental health care system, of which street-based mental illness is a large part in 21st century urban America, will not function for the treatment and care of clients until those responsible for mental health outreach, chiefly social workers and police, work together to transport those deemed a danger to self/others and/or gravely disabled to the hospital for psychiatric assessment. Importantly, the police cannot be made to feel as if they lack expertise in mental health simply because their opinions are lightly considered, if at all, in legal (mental health court) and medical (psychiatric assessment) proceedings (Rogers 1990). The label of interloper, or custodial, status must be removed from street-based mental illness policing in order for the mental health “bad call” to truly disappear. The police must be considered mental health professionals in their own way, professionals who work as members of a broader united system of clinicians and family members that cares for the mentally ill and pressures political institutions to provide sufficient basic needs (food, clothing, housing, transportation) and treatment (therapy, medications) to keep mentally ill individuals off the streets and in supportive environments in the first place.

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