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Authors

Segal, Steven P
Baumohl, Jim
Johnson, Elsie

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FALLING THROUGH THE CRACKS: MENTAL DISORDER AND SOCIAL MARGIN IN A YOUNG VAGRANT POPULATION*

STEVEN P. SEGAL

University of California, Berkeley

and

JIM BAUMOHL

Institute for Research in Social Behavior

Berkeley, California

and

ELSIE JOHNSON

Berkeley Support Services

Berkeley, California

Twenty-two percent of a young vagrant population reported on in this study, and believed to be representative of similar groups in many American cities, have been hospitalized for psychological disorder. These young mentally disordered vagrants are the most marginal members of the vagrant subculture, lacking social margin (i.e. resources, relationships, and a credible identity) with their families, community services and their peers. Their critical lack of social margin is due to an incongruence of expectations between disordered vagrants and potential benefactors. This incongruence generates a situation in which apparently eligible clients fall or slip through cracks in the service system. Ultimately, these individuals will become the core of a new chronically disordered and dependent population housed, at best, in community-based sheltered living arrangements as they grow older.

To prevent chronic mental disorder, psychiatric and social services must meet the needs of high risk groups. Although mental hospitals treat obvious psychological symptoms and public assistance is mandated to provide financial support for the psychologically disabled, these service enterprises do not adequately address the needs of young, mentally ill vagrants or "street people." Further, while the street scene has enjoyed a reputation as a milieu in which anyone is acceptable—even appreciated—and where meager wealth is shared, psychologically disturbed street people (DSPs), or "space cases" as they are called by their peers, rarely get equal or adequate consideration.

We use the term "social margin" to refer to all personal possessions, attributes, or relationships which can be traded on for help in time of need. This paper will document two facts: 1) that young mentally ill vagrants lack social margin both within the vagrant subculture and in the community at large; and 2) that their lack of social margin is largely due to the incongruence of expectation between DSPs and their potential benefactors (street people with resources, their families, community service institutions). One result of this incongruence is that DSPs—who by their lack of social margin risk becoming chronically disordered—are lost in our social service systems. They inadvertently fall or eagerly slip through its cracks.

Over the last fifteen years Berkeley's South Campus area has deteriorated from a lively, tweedy, Bohemian scene to a worn haven for young vagrants. This southern boundary of the

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"Athens of the West" has become the "Asylum of the West." Upper middle class counter-culture dropouts have been replaced by dropouts and pushouts from working class backgrounds. Because of their lack of education, skills and family support, they do not have the option of dropping back in. Moreover, Berkeley is not alone or unique in its status: Ann Arbor, Madison, Boston, New York, Atlanta, New Orleans, Austin and Boulder report similar populations with similar problems—most related to unemployment and psychological disorder. Observers in these cities—journalists, social workers, and others—indicate that youthful vagrancy is becoming increasingly problematic, and that the middle class, "student-tourist" aspects which characterized the heyday of hippiedom are either entirely absent, or apparent only during the summer. In short, there has been widespread agreement with the results of a recent Berkeley study which warned of the current and growing poverty of this American street scene (Baumohl and Miller, 1974; Mason, 1972).

METHOD

Our data derive from two sources. First, we gathered quantitative data during a one-week survey of patrons of the Berkeley Emergency Food Project during the last week of March, 1973. This survey involved the completion of self-administered questionnaires by 295 respondents (constituting an estimated 70.2% response rate), and structured interviews with 75 of these individuals (Baumohl and Miller, 1974). We collected qualitative material, our second source of information, during a year of close observation of the street scene in the South Campus area and nearby hotels, and of DSPs in institutional settings.

The survey method employed differed significantly from the method most commonly used to study vagrant populations. The study population was drawn from the patrons of a breadline rather than from a sampling of area lodging houses or transient shelters (Bogue, 1963; Priest, 1971). Two considerations prompted this variation. First, unlike a typical skid row area, honeycombed with free or low-cost shelters, Berkeley's South Campus lacks such facilities (the cheapest hotel is \$25 per week in advance), and many vagrants sleep in parks, laundromats, or on rooftops. Second, most street people dined frequently, if not regularly, at the Berkeley Emergency Food Project which served a free evening meal six nights per week at a location in the heart of South Campus. We chose The Food Project, as the study site because it included among its patrons those who would be missed in a survey of lodging houses: the most transient and disaffiliated. Since we timed the data collection to avoid the influx of summer "tourists," and since most street people frequently dined at the Food Project, we believe we captured a representative sample of the street population.

Field material reported in this paper comes from systematic observation of: 1) the formation and maintenance of friendship and exchange networks serving to distribute goods and services among street people; 2) the impact of psychological disturbance on an individual's ability to participate in these networks; and 3) the interaction between young vagrants and psychiatric and social service systems. We gathered qualitative material over the course of one year, using clinical contacts as points of entry into social networks. Observations were varied by time and setting to include the routines of various individuals and small groups under study. We observed interactions as individuals came into contact with service agencies. Direct quotes and descriptions included here have been selected from field notes (FN) and 40 tape-recorded interviews (I). All names and identifying characteristics have been disguised.

SOCIAL MARGIN AND MENTAL DISORDER

Social margin refers to the set of resources *and* relationships an individual can draw on either to advance or survive in society. It consists of family relations, friendships, possessions,

skills and personal attributes that can be mortgaged, used, sold, or bartered in return for necessary assistance. Social margin aids advancement and protects, or softens the fall of the downwardly mobile (Wiseman, 1970).

By personal attributes we mean certain traits which lead to the positive perception of oneself by others. To be regarded as reasonable, responsible, and trustworthy is to have an identity that can be traded on; to be regarded as irrational, unpredictable, and perhaps devious, is to have a "spoiled" identity which may command little sympathy and arouse suspicion (Goffman, 1963). A good reputation is critical to acquiring and maintaining social margin (Wiseman, 1970).

Social margin, then, especially for the poor, is a relational matter consisting of the good will of potential benefactors. The good will of potential benefactors—whether street people or bureaucratic functionaries—often depends on the "applicant's" compliance with pivotal role expectations. When expectations between benefactor and recipient are incongruent; i.e., when behavioral expectations on either or both sides cannot or will not be met, the benefactor is rejected and/or the applicant is outcast.

While causal priority has not been established, social margin and mental illness have consistently been associated in social science research. In this research, social margin has generally been measured by social class (usually a measure of wealth) or by social isolation (a measure of affiliation). The relationship between social class and mental disorder is consistently reported in social science literature. Lower class groups have higher rates of mental illness (Roman and Trice, 1967). Research on the relationship between social isolation and mental disorder indicates that geographic areas with higher rates of mental disorder are also characterized by higher degrees of social isolation (Faris and Dunham, 1939; Jaco, 1954).

Similarly, research indicates that the chronically mentally ill have little or no social margin (Miller, 1965; Segal and Aviram, *In Press*), implying that in order to identify populations which risk becoming chronically ill, at least two factors must be specified: 1) a prior history of mental illness and 2) an absence of social margin, the resources and relationships which might facilitate recovery.

Twenty-two percent of the young vagrants described by the Food Project data had been hospitalized for psychological problems. What remains to be demonstrated is that the psychologically disordered individuals in this vagrant population are seriously lacking in social margin, despite the fact that unlike most of their compatriots, they are members of the "worthy" poor and have legitimate claim to community support.

First, some words of clarification and caution. The only indicator of psychological disorder available in the quantitative data was a respondent's history of mental hospitalization. In our field research we observed those who were perceptibly disorganized for some prolonged period of time: those who were called "space cases" by others on the street. The "space case" is an individual viewed by peers as delusory and unpredictable. This traditional public conception of mental disorder does not differ on the street. To be regarded as a "space case," an individual need not be disoriented all of the time, but has severe and periodic psychotic episodes. To the extent that an individual is thought to "flip out" (break down) from time to time, he or she is regarded as a "space case." While "space cases" have invariably been hospitalized, not all those street people who have been hospitalized are "space cases." The relationships illustrated by the quantitative data, then, are weakened by the undifferentiated nature of the indicator (mental hospitalization). The more compelling picture of life without social margin portrayed by our observational material is due to an attention to immediate and evident disorder. Further, several of those who demonstrated significant disorder during the survey period were unable or unwilling to respond. Knowledge of some of these individuals leads us to believe that their response would have strengthened our quantitative findings.

SOCIAL MARGIN AND MENTAL ILLNESS WITHIN
THE SUBCULTURE OF VAGRANCY

Why, in a social milieu with a dense population, should any person be isolated? (Dunham, 1964, p. 144).

On the street, resources derive from different "hustles" or "scams," ranging from garbage scrounging, panhandling, and shoplifting, to the more organized and highly entrepreneurial activity of dope dealing. Resources are distributed through networks of friends whose social and economic activities blur to form the gestalt of a vagrant lifestyle. Having friends with whom credit may be established and with whom privations may be shared and thus diluted, is crucial to riding out hard times. The individual who is not adept at making friends, or who lacks practical intelligence and integrity, will have a difficult time on the street. Street society is a crazy-quilt meritocracy with poignant expectations of competence. Street society provides avenues of upward mobility or survival for some, but compounds the perceived weaknesses of others by isolating them from sources of support. Its social order is not much different from that of the wider society.

Survival is a serious business. While street people are abstractly supportive of the values of human dignity and social responsibility, they are far more concerned with the day to day issue of "getting over." A hustle is valued according to 1) its usefulness to survival; 2) the dignity it affords; and 3) its moral righteousness. Further, while charm and "personality" are valued, it is competence, trustworthiness, and a sense of responsibility which makes an individual attractive and economically successful. These are the pivotal expectations of street life.

The most highly respected street occupation—because it is relatively lucrative, dignified, and moral ("it doesn't hurt anyone, and provides a service") is dealing in marijuana and LSD. In fact, dealing is the backbone of the street economy; the frequently long chain of transactions leading to consumption provides many jobs and brings in most of the community's real income.¹ Those who are excluded from dealing are relegated to less remunerative, less dignified, and less ethical pursuits. The mentally disorganized are usually excluded from dealing except when they can peddle their antipsychotic medication. Further, for reasons we will discuss below, they are not very successful even in a lower status occupation such as panhandling.

Dealing, and successful street living in general, require considerable skill in managing interpersonal relations. Typically, those who have, are wary of those who have not; street people with money and/or "connections" take a rather Hobbesian view of their world, reflected in the informal (but enforced) "rules of association" followed by dealers. Many of these rules are related to managing social boundaries with strangers—customers and unknown connections in particular. The most fundamental of these rules divide the street population into "safe" and "unsafe" groups. Included among those street folk uniformly considered unsafe are "rip-offs" (usually "junkies" and "speed freaks") and "space cases."²

"Space cases" are judged unsafe because they are regarded as incapable of appropriate association. DSPs are alleged to be incompetent, irresponsible, illogical, and unpredictable;

¹ The two biggest dealers on the street had, between them, approximately \$3000 "in the bank" after seven months of work. On the street this is a staggering amount of money, and only the rare dealer who can dominate trade will do this well. Most dealers are lucky to raise enough in a week to cover food, a hotel room and pocket money.

² Others not uniformly considered unsafe to associate with, but avoided selectively, are runaways, "winos", and "rowdies." Alcoholics, "rowdies", and "junkies" tend to form their own social networks, whereas the few runaways in South Campus latch on with whatever network of street people will accommodate them for awhile. "Speed freaks" and "space cases" tend to be loners.

in short: dysfunctional. The DSP "just can't avoid trackin' dirt in the house, if you know what I mean" (FN). To the dealer, the DSP is as much of a liability as a thief:

Space cases, man, are crazy, y'know? You can't trust 'em. Not, y'know, because they're dishonest or nothin', but they just don't know what they're doing most of the time. You can't sell 'em nothin', y'know, put 'em in business 'cause they'll just get busted. And maybe you with 'em . . . The best thing to do is just shine 'em on. Not even let 'em know you got nothin', y'know; if a space case asks to buy some acid, y'know, I say "what acid?" You don't want to let 'em in 'cause then they'll be bringing you customers.³ I mean all sorts of weird space cases'd be comin' by if they know you got something. Bringing god knows who at all sorts of times, and just wantin' fucking two joints, or maybe two hits or something, y'know? It ain't worth it. (I)

Excluded from dealing, and from significant social contact with dealers, DSPs are not only isolated from the street's major route of upward mobility, but also from individuals who have resources to share. It is not uncommon for dealers to take people in, allow others to use the kitchen facilities in their hotel rooms, or help raise bail. While dealing is undeniably a business, dealers, like Kiwanis members, feel some philanthropic obligation. By sharing their shelter, food, and even money, dealers gain the satisfaction of simultaneously "spreading good vibes" and portraying themselves as honest, charitable businessmen.⁴

In a milieu where individuals pride themselves on self-reliance and practical intelligence, one who is perceived as incompetent is also regarded as pitiable and undignified. The DSP's delusions, erratic and often garbled communications, and personal affects are viewed with such feeling by dealers and other street people alike. Street people, like most "normals," are embarrassed by the mentally disordered, and also moved to concern. On the street, however, concern for DSPs is constrained by an acute attention to security from theft or arrest, and by a sense of the futility of aid. With respect to avoiding contact with the police by maintaining a safe distance from "space cases," Pancho, a well-traveled and experienced panhandler, says that:

Personally, I can kind of shine 'em on enough to put up with 'em most of the time. But they're so obviously fucked up, y'know, that they kind of draw attention to themselves . . . Like, if you panhandle near one of 'em, y'know, you're likely to get hassled by the pigs, y'know, 'cause they check out the heavy space cases to make sure the dude isn't gonna really flip out or fall down and die or somethin'. You don't want to get too close to that, y'know, 'cause they might start askin' *you* for ID and shit. And like I got a hitchhiking ticket I ain't paid, or so-and-so's got a joint in his pocket, y'know? (I)

The following incident illustrates the limits of aid other street people offer DSPs. In this case aid takes the form of indigenous chemotherapy. Like most mental health professionals, street people perceive no other alternative to the institution for those who "can't take advice" and look after themselves.

At about 11 pm there was a loud wailing and cursing in the hallway. George, a space case living across the hall, had come back to his room and found his door kicked in and all his possessions stolen. Brett, Alfred, Susie and I stopped our card game. Alfred got up

³"Bringing customers" is a way street people may profit from dealing without really being dealers themselves. An individual brings a customer to a dealer having quoted the customer a price somewhat above the dealer's. After the transaction the "middleman" is paid the difference by the dealer as a sales commission. By this device dealers move their goods more quickly, and allow participation without increasing competition.

⁴All dealers like to project this image of themselves; many live up to it but others do not. One major dealer, who had several others "working the street" for him, was particularly fond of recalling his contributions to social welfare. His "employees"—who (correctly) suspected him of hiding his profits by lying about his costs—frequently referred to him as "John D."

impatiently, and quickly rolled a joint on the bed. "You guys wait here, I'll take him this," he said. "What else can you do?" Brett said after Alfred had gone. "The guy's totally spaced out; no way to really help him feel any better." Susie added that George should be in a hospital "where maybe he can get some help." (FN)

A week later I asked Alfred about the night George's room was burglarized:

Alfred, you say you're into helping people. What can you do for George, for instance?]

Oh, man, why don't you pick an easy one? You embarrass me! No, I'm joking, of course . . . Well, on the street I can help people—usually, y'know. You got a money problem, a problem with your old lady, your old man, I can help you. I don't know why [but] people just come to me and take my advice . . . And it must be pretty good because they usually do what I say and they get it together . . . But people like George, y'know, a space case, how can I give him advice? He don't know what the fuck I'm talking about! He's crazy, y'know, you can't say nothing to him. He don't understand. (I)

"Space cases," then, are liabilities to other street people, and are excluded from the friendships which serve to distribute earnings (resources) from panhandling, "bringing customers," petty theft, and other hustles. Consequently, DSPs are often loners, left to find their own make-shift shelter and sources of food and income. The Food Project survey data reflect this lack of social margin. Among the survey respondents, only 18% of the never-hospitalized group report that they "never" or "rarely" visit with a friend, as opposed to 33% of those previously hospitalized ($p < .005$). Expectedly, the formerly hospitalized DSPs found it more difficult to gain access to social activities ($p = .06$), and were significantly less likely to have access to cooking facilities ($p < .01$).

With regard to shelter, the survey data do *not* show that previously hospitalized DSPs were more likely to be "crashing"; i.e., sleeping somewhere without paying rent. However, the formerly hospitalized were likely to have been "crashing" for longer periods of time ($p = .07$). This finding seems to corroborate our observation that the DSP experiences an enduring isolation, and unlike other street people does not move rapidly in and out of a more stable residential pattern.

Without the protection and counsel of friends, DSPs are extremely vulnerable to exploitation, robbery, and physical abuse, especially from heroin addicts, the street's notorious "rip-off artists." Afraid of arrest or involuntary commitment, bewildered by bureaucratic procedure, and highly sensitive to the "sophisticated" skepticism of law enforcement personnel, DSPs are unlikely to report abuses. This, of course, makes them even more attractive "marks." It is not surprising that among our respondents, 41% of the formerly hospitalized, as opposed to 27% of the never-hospitalized, did not feel safe on the street most of the time ($p = .10$).

In their isolation, DSPs frequently panhandle for their daily bread. Unlike dealing, which is fairly well organized and subject to participant regulation, anyone can "spare change." Successful panhandlers are talkative, amusing, and clean; DSPs are frequently withdrawn or incoherent ("spooky" rather than amusing), disheveled and dirty. They tend to be avoided by passers by. A young woman or a panhandling team (usually two people working opposite sides of the street) may solicit several dollars in an hour or two, but DSPs rarely get more than three to five dollars during a whole day.

To supplement panhandling earnings—or even a meager General Assistance allowance—DSPs may scrounge garbage or collect deposit bottles. Scrounging of this sort is derogated by other street people as undignified, and on occasion, when a "space case" is rummaging through a garbage can in full view of others, he or she will be driven away with the admonishment that "you ain't no fuckin' dog." This is not cruelty, but rather the equivalent of a stern and frustrated "pull yourself together" or, more colorfully, "get your shit together." On the street, there is little more which can be said or done.

CONVENTIONAL SOURCES OF SOCIAL MARGIN

There are two conventional sources of social margin for DSPs: their families of origin and the formal system of community services. As few DSPs are married, we will only be concerned here with relationships to the family of origin.

Family and Social Margin

Street people have widely varying relationships with their families. Some report being the family's "black sheep," cut off from all financial or social support as long as they fail to meet important parental expectations concerning education, employment, and life-style characteristics. Many, perhaps most, have achieved an ill-defined, uneasy peace with their families. The survey data show that 80% of the total group have maintained some tenuous contact with their parents—an occasional phone call or letter. However, only 23% of the respondents reported receiving money from home—usually insignificant amounts—during the previous month. This percentage does not vary between previously hospitalized and never-hospitalized groups.

There are, however, indications that previously hospitalized street people are more estranged from their families than others on the street. The previously hospitalized frequently report that their families "don't understand my problems," "had me committed in the first place," "want to put me away," or "simply hate me." (Quotes are from structured interviews with survey participants.) This is often true even among those who receive periodic assistance from home; the parent who gives with one hand may devastate with the other:

Leonard, a man approaching thirty who had been hospitalized for acute depression following his father's death three years before, received a check from his mother. In the envelope was a letter in which she told him how "sick at heart" it made her to send money to her son "who is such a bum." "For a lousy five bucks I gotta listen to this," he said. "If I wasn't so broke I'd rip it up and send back the pieces." (Two months later) Leonard was hospitalized today; he was alternately quiet and depressed, then hysterically incoherent, claiming Berkeley Support Services staff as his family. He didn't want anyone to call his mother. (FN)

We find that while 81% of never-hospitalized street people "never" or "rarely" visit their immediate families, 92% of the formerly hospitalized manifest this degree of estrangement ($p = .09$). Further, members of the hospitalized group are less likely to perceive their parents as willing to take them back into the house if the need were to arise ($p = .10$).

But very few street people (6%)—regardless of previous mental hospitalization—express any desire to return home. A "survival ethic", stressing independence and self-sufficiency, permeates the young vagrant subculture in which even the "space case" is a marginal participant. Street people, for better or worse, are on their own; they expect and ask for little from their families, with whom their relations seem strained, at best.

Community Services and Social Margin

Community service institutions exist to serve those in need. Each institution, though, harbors expectations of the characteristics appropriate to "serviceable" clients or patients. These expectations are largely structural. They derive from the statutorily or procedurally defined attributes ascribed to those who are suitable for or worthy of service and/or control. Such expectations reflect the institutions' norms for residential stability, familial affiliation, reality orientation, and define the parameters for services provided by the institution's functionaries. Ostensibly, these regulations and guidelines represent the "balanced interests" of the community at large, the helping community, and the client community. Even if some

regulations appear miserly or misguided, workers enforce them in perfunctory style. They do their jobs.⁵

DSPs find the expectations of service institutions problematic in two ways. First, some expectations are perceived as threats to competence and autonomy; second, institutions may expect serviceable clients to possess at least minimal resources, e.g., a domicile. DSPs are alienated from their families, and on the street are discredited, isolated, and lack resources. Therefore, they often lack the "starter materials" required of serviceable clients by agencies. DSPs, therefore, often feel that institutional expectations reflect an ignorance of, or a disregard, for who they are and what their social circumstances are like. Understandably, this is often initially expressed in hostility toward the worker. In an extreme case, one DSP who was being "walked through" a Supplemental Security Income application, leaped over the worker's desk when reminded that his claim would be delayed by the multiple psychiatric interviews necessary to certify disability. Later, the DSP may express outright rejection of the service system as a whole (see below).

To appreciate the DSP's lack of social margin with community service institutions—in particular, with the State Mental Hospital, the psychiatric aftercare system, and public assistance and social security programs—we must first examine the DSP's self-perceived identity, and then his/her interactions with service institutions in which mutual expectations are mediated.

Self-Perceived Identity of DSPs

While "space cases" are viewed as incompetent, irresponsible liabilities, they frequently believe that they are not as crazy as others think they are. This belief forms their thin crust of self-esteem. DSPs, after all, do survive. They make do; they get by. Just as with their "normal" counterparts, survival becomes their badge of competence and autonomy. The high value street people, and thus, DSPs, place on self-sufficiency and autonomy cannot be over-emphasized; combined with their powerless status it creates an abiding hostility to psychiatric and social service institutions. Regardless of their intent, these institutions frequently seem to quash their clients' abilities to act autonomously and competently.

Pack Rat, who is 21, has been released from the hospital and is once again living in the crawl space beneath a church. He was arrested for shoplifting and diverted to the State Hospital. He was released after 72 hours:

'The hospital ain't too bad. You do what they want and they let you go. Tell 'em you're going home or whatever.' I ask why he doesn't apply for Social Security and live in a hotel. 'What can I say? A hotel would be nicer than this, yeah, sure. It'd be nice to have bread. But their system's so fucked up, y'know? Like I don't think I'm *that* crazy, but, you know, I need the bread . . . But they won't give me any money until I confess my sins, man. I gotta say 'yeah, man, I'm a fuckin' lunatic', and sign ten forms and see eight doctors to prove it. And then they might really lock me up! Shit, at least here I can hustle a little, you know, and be free, not living in some cage like some animal. I do okay. Fuck 'em.' (FN)

Pack Rat, an eloquent "adolescent schizophrenic," expresses sentiments common among DSPs. First, he prefers to be regarded as poor, as opposed to "crazy." He feels that aid should be dispensed on that criterion alone. Second, he feels that he is sufficiently competent to take care of himself and should not be "locked up like an animal." He does not, though, trust "the system" to allow him his freedom if he concedes that he is psychiatrically disabled.

⁵ Some workers and supervisors can, of course, be manipulated by a skillful client or client advocate. However, in our experience this has rarely gone beyond areas discretionary to begin with. For a different, and perhaps exaggerated, view of worker deviance see (Jacobs, 1969).

(On the street, Pack Rat's competence may be questioned, but his autonomy is never challenged.⁶) Third, Pack Rat expresses a thorough-going hostility to authority, which he perceives as "fucked up." In sum, Pack Rat—and others like him—feel that the expectations of service institutions indicate a misappraisal of his situation, a humiliating denial of his competence, and a threat to his autonomy. We turn now to the interactions which may engender such misgivings about help.

Mental Hospital Admission: Equating Treatment with Law Enforcement

DSPs most often arrive at the mental hospital through the process of involuntary commitment. In fact, during 1973, roughly 75% of all Berkeley's admissions to the State Hospital were involuntary and these admissions were concentrated in the 20-29 year old age group. Although involuntary commitments may be initiated in a number of ways, DSPs usually experience hospitalization as the result of a police encounter—either in connection with the adjudication of a minor offense (petty theft, panhandling, trespassing) or because they appear "gravely disabled;" disoriented and unable to care for basic needs (California State Department of Mental Hygiene, 1969).⁷ In either instance, DSPs are taken (in custody) to a psychiatric facility for observation, evaluation and, if need be, transport to the State Hospital.

DSPs experience involuntary commitment as a serious affront to their sense of competence and autonomy; they find that it robs them of what may be their last vestige of autonomy, their freedom of movement. Moreover, DSPs—who tend to define their problem as poverty rather than insanity—perceive a nefarious cooperation and similarity of style between law enforcement and psychiatric personnel. Unilateral authority over the "space cases's" body is passed routinely, if not always smoothly, from policeman to psychiatrist or social worker, and they decide what is best. They talk in codes and fill out various forms; the doctor listens and makes ominous notes to which the patient is not privy. Patients who become overly anxious about what is happening to them may be injected with a tranquilizing agent.

This procedure is most troubling and bitter for those DSPs who, at the shock of official apprehension, suppress their delusions ("come to"). These individuals often find that it is the police officer's testimony to the mental health worker ("wandering in traffic and unresponsive to questions"), their appearance, a prior history of hospitalization, and their vagrant status which provides the rationale for commitment. Despite their coherence, their reputations are tarnished, and they have no social margin to negotiate an identity more to their advantage than "gravely disabled."⁸

DSPs are alone, without resources and, at least at times, sufficiently disoriented to become public nuisances. They are "gravely disabled," and as such are trundled off to the hospital, where they are to be sufficiently rehabilitated to establish social relationships, and where resources are to be prepared for them. Hospitalization marks the beginning of a process whereby those lacking social margin are to be helped in acquiring some.

DSPs, however, have not asked for therapy. They may define themselves as poor, as out-

⁶ Even the DSP's competence is rarely questioned directly. Usually, the DSP is "shined on." To "shine someone one" is pleasantly to ignore the person or agree with whatever is said without incurring any obligations. In essence, it is discreetly to deny another's claim to one's attention.

⁷ Section 5150 of California's Lanterman-Petris-Short Act allows the involuntary detention of individuals who appear to be a "danger to themselves or others," or "gravely disabled." Mental health workers usually refer to those individuals hospitalized under this Section as "5150's" (California State Department of Mental Hygiene, 1969).

⁸ It is this concatenation of problems stemming from a lack of social margin which prompts Wiseman (1970), to assert that social margin multiplies and disappears geometrically rather than additively. The more one has, the more one can get; the less one has, the harder it is to generate.

cast, as politically disagreeable, but they rarely perceive themselves as "crazy." Yet, against their wishes, they become mental patients. Thus, they may come to identify the hospital with jail, and hospital personnel with jailers. Consequently, they react to their incarceration in a manner simultaneously cooperative and mistrustful: they meet the minimum expectations of their captors—they "improve"—but leave the hospital as soon as possible, often before any program of secondary prevention can be planned.

Mental Hospital Care: Mental Health In 72 Hours

DSPs are often assisted in their rapid departure from the State Hospital by administrative pressure for quick release. Given California's emphasis on community-based care for the mentally ill, long-term hospitalization is seldom financially or politically feasible. Whether patients are admitted to the State Hospital voluntarily or involuntarily, there is pressure exerted to discharge them after 72 hours, if there is sufficient improvement in manifest symptoms.⁹ The arrangement of social and psychiatric support services in the community is secondary to the treatment of symptoms and patients judged psychologically prepared to reenter the community after 72 hours are released, frequently without regard to material concerns, which usually cannot be settled within 72 hours of admission.

Quick release, of course, suits the DSP just fine:

Jeannie finished an agonized description of her police pick-up at the Greyhound Station: 'the policemen were laughing at me while they handcuffed my hands behind my back.' I asked what happened when she reached the hospital. 'I made up my mind to be out of there by the end of 72 hours. I knew what they wanted to see, so I took my medication and gave them my good girl routine.' (FN)

Release after 72 hours, however, seriously impairs the ability of hospital staff—usually social workers—to arrange adequate community care. The social worker, knowing this, attempts to persuade patients to remain in the hospital on voluntary status "just long enough to let us get something done" (FN), but DSPs usually want out and, especially when they are in on involuntary 72 hour detention, are not inclined to trust offers of help from representatives of a system which may have brought only grief. Administrative cross-pressures for quick release generally prevail.

AFTERCARE: FALLING THROUGH THE CRACKS (PART I)

The hospital staff's concentration on psychological symptoms is justified by the existence of an aftercare planning system. Designed to attend to the basic needs and treatment of patients leaving the State Hospital, this service provides halfway house, board and care, and day treatment placement, and assistance in securing financial support from public assistance programs. In short, it is a brokerage service designed to increase the social margin of ex-mental patients by providing resources and psychiatric treatment for the rehabilitation of their identities.

In fact, the aftercare planning system is severely limited in its ability to deal with those individuals who stand to derive the greatest benefit from its services. Gaps allow DSPs to fall or slip through unserved.

DSPs and Aftercare Planning. In the area where this study was conducted, aftercare planning is the responsibility of community-based mental health workers called "hospital liaisons."

⁹Patients admitted under Section 5150 of Lanterman-Petris-Short must have their status reviewed within 72 hours of detention and, except where patients successfully appeal medical judgment, longer periods of involuntary commitment may be permitted. Lengthy involuntary commitments unrelated to violent crimes have become rare in California.

The system allows only one day a week of liaison work at the hospital. Since DSPs usually leave the hospital as soon as they can; i.e., after 72 hours, they do not see their liaison worker unless they are "on a hold" when the worker visits. In addition, patients must designate a mental health district to which they wish to return in order to be assigned a liaison worker. DSPs, wary of the power of official cognizance and skeptical of its benefits, sometimes assert that they are leaving California, or "haven't decided" where to go. These individuals are not assigned to a worker.

If no liaison is made, either because the patient stayed too briefly or chose no district of return, notification of the patient's departure from the State Hospital is sent to the community mental health district in which his or her last known address is located. A follow-up letter is sent from the local agency to the patient at that address. For the DSP, who has no address, or changes it frequently, this procedure is useless. DSPs disappear from official view.

Even when DSPs meet with a liaison worker, they rarely meet the worker's expectations. Liaison workers are usually harried. They are at the hospital one day each week and, since they are not employed full-time in their liaison capacities (they have their own out-patient caseloads), they must budget their time. Liaison workers develop a system, known as "creaming", which applies more time and energy to cases where there are good possibilities for "successful rehabilitation." They do not base their hope of success on psychiatric diagnosis. Rather, liaison workers have two crucial expectations of patients who would not be "creamed out", or neglected. First, they must remain in the hospital long enough for the worker to get to them. Depending on when the patient is admitted, this could mean a hospital stay of a week or more before service activities begin. (Involuntary patients normally would need to transfer to voluntary status.) Second, patients must be precise about post-release settlement plans; liaison workers will not act in the face of ambivalence or indecision. Patients must express an interest in placement, out-patient therapy, and/or financial aid—or the liaison worker goes away.

DSPs are as wary of liaison workers offering suggestions of halfway house or board and care placement (perceived as more confinement) as they are of attendants bearing phenothiazines. Despite workers' sincerity and patience, DSPs find it curious that their rights of self-determination are suddenly respected. Understandably, they feel that there must be a catch; they feel that liaison workers are wolves in sheep's clothing. While some DSPs are hostile toward their liaison workers, most "shine them on": they become glib and non-committal. Interactions between DSPs and liaison workers resemble those between DSPs and drug dealers, except that in the hospital it is the DSP who does the "shining." Thus, DSPs brand themselves as bad investments. With regard to DSPs, the liaison worker may say:

I don't know what happened to the guy. I guess he went back to Texas . . . Sure there is less service for people who fall into this pattern [vagrancy], but hell, I'm just not in a position to put in a lot of time and energy on a guy who may split on me two weeks later. (FN)

Liaison workers believe that DSPs will be neither responsive to, nor suitable for, community placement. At best, they feel they might convince DSPs to "check out" the Welfare or Social Security Office in the area to which they return. Liaison workers and hospital social workers frequently regard the hospital as a "dumping ground" for young vagrants. As a social worker lamented:

We see so many of these kids here. They come in on a hold, and they're angry at us. Their symptoms are real, but usually harmless and there's very little we can do for them . . . They leave and go back to the street I guess. (FN)

WELFARE: FALLING THROUGH THE CRACKS (PART III)

In the State Hospital DSPs resist expectations applied to the "good" mental patient because they feel humiliated and robbed of their freedom. In dealing with the mental health system they are also disadvantaged by their vagrant status. They cannot be contacted by mail or regularly found at any address by aftercare or community mental health workers. Still, the mental health system makes minimal demands upon its patients for the possession of resources. As a system, it fails with DSPs because of the coercive nature of the involuntary commitment process. Public assistance programs, on the other hand, make possession of, or access to, basic resources virtually indispensable to eligibility; they are in the curious position of requiring that applicants have some resources before others will be made available.

Even if DSPs are willing to present themselves to authority as psychiatrically disabled—an admission of incompetence which, as Pack Rat tells us, is often feared and resisted—they face the institutional expectation that they have a domicile. The implementation of this expectation differs considerably between the two aid programs most important to DSPs, Supplemental Security Income (SSI), a federal program administered by the Social Security Administration, and General Assistance (GA), a county-run program.

DSPs and Supplemental Security Income (SSI). Applicants for SSI must, of course, prove their claims of disability. They must be willing and able (sufficiently oriented) to provide specific dates of hospitalization and other treatment, names and addresses of treating physicians and clinics, the nature of the disability, and current financial situation. An inability or unwillingness to supply this information correctly usually means denial of the claim. Then, after the initial phase of the application process has been completed, applicants must be interviewed—often more than once—by state appointed or approved psychiatrists.

Even if the application is adequately initiated, the lack of a permanent address greatly increases the likelihood that the DSPs application process will not be completed. Notification of psychiatric appointments, requests for additional information or release forms, and all other communications from the Social Security Office are made by mail. Since this process may take anywhere from three to six months or more, its completion is obviously difficult for the DSP, whose address changes from week to week or, in reality, does not exist. Forms which are undeliverable, and therefore returned, make the DSP's whereabouts unknown. "Whereabouts Unknown" is then stamped or written in the DSP's file, which is then considered closed.

The major dilemma, for DSPs attempting to negotiate the SSI application process, is securing the resources necessary to stabilize their residential situation. Given the status of DSPs on the street, how is this to be accomplished?

DSPs and General Assistance (GA). The DSP's only immediate source of revenue from the welfare system is a county program called General Assistance. Although state administrative guidelines have established "intent to reside" as the only legal residence requirement for the receipt of welfare benefits, it is left to county administrators to define "intent." In most counties this is done by requiring proof of current residence, in the form of a statement signed by a landlord verifying the rental of a room or apartment. DSPs, who lack the initial rent deposit, and friends who might let them "borrow" a room for the purpose of a landlord's statement and the GA worker's home visit, cannot effectively prove that they are residents anywhere. In addition, counties, by setting low rent ceilings for GA recipients, limit the amount and kind of housing available to them, and make DSPs non-competitive for the few available board and care or halfway house beds.

For the most part DSPs eschew public aid programs because these programs expect DSPs to have minimal resources already. There is an additional expectation by some GA programs

which insults the DSP's sense of autonomy. California welfare legislation declares that parents are legally responsible for the financial support of their children—regardless of age—and in some counties all GA applicants must agree to permit the Welfare Department to contact their parents regarding the "child's" dependent status. In these counties, young adults, applicants aged 18 through 20, are routinely excluded from GA. Unless they can *document* exceptional circumstances, such as potential physical or psychological abuse or prolonged prior separation, 18 to 20 years old applicants are expected to return home. This "responsible relative" provision attempts, by fiat, to revive severely impaired relationships between young adults and their families. For older applicants, it is often a source of acute embarrassment. Cynically, we might suggest that the "responsible relative" provision fulfills the purpose for which it was created: it discourages applications for aid.

CONCLUSION

Because they cannot meet their potential benefactors' expectations, DSPs lack social margin. On the street, DSPs fail to meet their peers' expectations of competence, and come to be regarded as liabilities. As a result, they are discredited, socially isolated, and lack resources. DSPs also fail to meet the expectations of community service institutions and thereby obtain unfavorable, unserviceable, or ineligible identities. In some part, DSPs fail to meet institutional expectations because they cannot: by the time they approach these agencies they already lack social margin and cannot wait patiently in one place while the wheels of bureaucracy grind slowly toward resolution. And in some part, they will not comply: they are young, proud, and jealous of their autonomy. In their relations with community service institutions, they expect to be hassled, discredited, and delayed, in the end receiving nothing, and perhaps losing their freedom.

It is our contention that the absence of social margin experienced by young, mentally ill vagrants places them at high risk of becoming chronically disordered. In time, we may find these individuals are the core of a new chronically ill population. As they get older, and more chronically ill, DSPs will, perhaps, be housed in community-based, sheltered care facilities rather than in large state mental hospitals. More probably, they will drift through run-down welfare hotels and be repeatedly involved with police and mental health agencies as a result of public complaints.

Admittedly, this is a discouraging vision, and perhaps we have misread the portents. Still, any system designed to deliver therapeutic services will fail with this population unless the complex, interrelated issues considered here are adequately resolved by statutory reform and administrative and clinical practice. An effective therapeutic and social support system will need to be founded on a radically different conception of the "worthy poor" and will require a more humane method of keeping "street crazies" from harm.

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