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Challenges to Psychiatric Care: A Clinical and Anthropological Analysis of Psychosis and Dependency

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Challenges to Psychiatric Care: A Clinical and Anthropological Analysis of Psychosis and Dependency

A dissertation submitted in partial satisfaction of the requirements for the degree Doctor of Philosophy in Anthropology

by

Blake Robert Erickson

2023

ABSTRACT OF THE DISSERTATION

Challenges to Psychiatric Care: A Clinical and Anthropological Analysis of Psychosis and Dependency

by

Blake Robert Erickson

Doctor of Philosophy in Anthropology

University of California, Los Angeles, 2023

Professor Laurie K. Hart, Chair

(Through a multidisciplinary approach based in anthropological theory, participant observation methodology, and psychiatric practice, this dissertation explores the lived interplay between psychotic mental illness and functional dependency in seven ethnographic cases of patients, families, and medical providers. Chapters address historical context, the spaces (i.e. homes, jails, shelters, streets) in which treatment and care are administered to psychotic and dependent persons, the ways in which psychiatric crises are handled by social workers and police officers, and the psychiatric and medical patient outcomes when basic needs are neglected. A conclusion and appendices propose clinical and social interventions to decrease this neglect and to increase patient empowerment).

The dissertation of Blake Robert Erickson is approved.

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2023

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VITA/BIOGRAPHICAL SKETCH

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Challenges to Psychiatric Care: A Clinical and Anthropological Analysis of Psychosis and Dependency

INTRODUCTION

Historically, psychiatry and anthropology have had a mutually productive relationship in academia (Kaiser and Kohrt 2019). From influential psychiatrists like W.H.R. Rivers, Sigmund Freud, and Emil Kraepelin writing on issues of culture, trauma, neurosis, and psychosis at the turn of the 20th century, to the early-to-mid-century psychological writings of anthropologists Margaret Mead and Ruth Benedict, to mid-to-late century friendships and collaborations between psychiatrists and anthropologists like Harry Stack Sullivan and Edward Sapir, as well as between Clyde Kluckhohn and Dorothea Leighton, the line, over the past 150 years, between psychiatric research and anthropological studies of culture, society, politics, and economics has often been blurred (Janis H. Jenkins 2015, 7–9; Rivers 2001; Freud 1930, 57–146; Jilek 1995; Mead 1928; Benedict 2005; Sullivan 1939; Kluckhohn and Leighton 1974).

With the release of the Diagnostic and Statistical Manual III (DSM III) in 1980 and an industry-wide shift to managed care over the course of a decade, however, American psychiatry, as a profession, made a move from dynamic and psychoanalytic toward psychopharmacologic frameworks that decoupled the aforementioned collaboration (Luhrmann 2000; Luhrmann and Marrow 2016, 1–25). This decoupling was furthered by the fact that, by the 2020s, the National Institute of Mental Health (NIMH), a primary funder of mental illness research in the United States, had relegated clinical research to 10% of its research funding budget, and allocated the majority of its moneys to basic neuroscience (Torrey et al. 2021; Makari 2023; Torrey, Simmons, and Dailey 2023). Thus, while crossover continues to occur between anthropology and psychiatry today, with anthropologists and psychiatrists holding dual academic appointments and a small, but growing, number of MD/PhD psychiatrist-anthropologists entering the fray, funding for this type of collaborative research can be slim, and such generative, on-the-ground work can be overshadowed by in vogue neuroscientific studies (Kaiser and Kohrt 2019).

Like other MD/PhDs in the psychiatric-anthropological space, I seek to recapture some of the pre-1980s collaborative spirit and to revive attention at the generative border of anthropological theory and methodology, and psychiatric practice. While writing this dissertation, I also completed medical school and psychiatry residency training. Rather than separate these professional experiences from an anthropology of mental health, I integrate ethnography, theory, and clinical perspectives in this dissertation. I suggest that this mix permits a unique lens through which to not only illustrate, but also to propose ways to intervene on, the health disparities that impact the lives of the most vulnerable persons living with psychosis.

Anthropology distinguishes itself from other academic disciplines in its longitudinal and in-depth qualitative follow-up of research subjects. In an era of intense fragmentation of public mental health care in the United States, perspectives like these, which cannot be had in purely cross-sectional or quantitative works, are rare opportunities to assess patients' lived experiences. Throughout this dissertation, I highlight the fertile nature of qualitative research, with a focus on participant observation and case study - two foundational anthropological methodologies that are increasingly deemphasized in modern medical research. Observation, the first step of the scientific method, allows for the empirical generation of research questions. Phenomenological psychiatric research into the "meaningful forms through which distress is articulated and constituted as social reality" (Good and Kleinman 1985, 298) has been, and continues to be, fundamental to the development of psychiatric knowledge. To name just a seminal few examples, the importance of clinical observation to therapeutic advance can be seen in Emil Kraepelin's inductive nosology, Eugen Bleuler's introduction of the disorder of schizophrenia, Sigmund Freud's development of psychoanalytic diagnoses and concepts, Donald Klein's work on pharmacologic dissection and panic attacks, Robert Spitzer's leadership on diagnostic classification, and, recently, precision psychiatry (Fernandes et al. 2017; Scull 2015, 263–65, 387–89; Spitzer and Endicott 1979; Klein and Healy 1996, 329–52; Breuer and Freud 1975). Case study serves a critical organizing and generative role in the translation and communication of academic data (Kleinman 1988; Mattingly 2007; Breuer and Freud 1975, 160–61). Without stories, readers lack bases on which to evaluate and compare their own observations and experiences, and to connect with and learn from the presented material. Case study provides the content – the language – for productive listening, empathetic imagination, comparative reflection, and academic debate.

I present the dissertation in two parts. Part 1 includes core ethnographic fieldwork obtained, and theoretical analyses developed, during my anthropology PhD research. Part 2 comprises peer-reviewed manuscripts that emerged from my professional psychiatry practice during the past 4 years of residency training, and which fuse psychiatric and anthropologic ways of thinking. Some of these pieces were collaboratively written and published, as is customary in medical literature (see Appendices A, B, D, E). I also include a working autoethnography on my residency experience treating patients, and witnessing mass death, at the height of the COVID-19 pandemic in New York City in spring 2020 (see Appendix F). This is an experience that I have yet to completely grasp as of this dissertation writing in summer 2023. The memoir in formation explores the psychic costs of care, corporate power, and social inequality. Memories of this experience were in the background to all I have written in this dissertation; I do not feel the dissertation would be emotionally complete without their being included here.

I scaffold Part 1 of the dissertation around the ethnographic case study of Brian*, with whom I conducted participant observation fieldwork for a continuous year. Brian's case tells a foregrounded story of psychosis and dependency at this particular historical moment in community mental health care (Chapter 1). This is a story of the spaces – including homes, jails, shelters, and streets - in which treatment and care are administered to psychotic and dependent persons (Chapter 2). It is also a story of the psychiatric crises that psychotic and dependent persons can undergo, how the police do and do not intervene in such dilemmas, and how violent acts forecast obligatory dependency in the way of hospitalization and incarceration (Chapter 3). Brian's case further highlights the tenuous divide that exists between those like him who receive basic needs support from kin, and others who exhibit psychotic symptoms, have little to no social support network, and experience gross neglect and destitution. Such a contrast illustrates how neglect of underlying dependency issues can lead to appalling health (e.g. untreated chronic medical illness) and social (e.g. homelessness) outcomes for psychotic persons (Chapter 4).

PART 1

Chapter 1

Ethnographic Prelude

I stand over Evelyn's shoulder as she reads an email from Meghan. Evelyn is a social worker who provides case management services to persons with serious mental illness like Brian, Meghan's son who has been diagnosed with schizophrenia. In the email, Meghan describes calling 911 in the hopes that Brian would be brought to the hospital for psychiatric assessment, as Brian appeared to her to be psychiatrically decompensated. The police assessed Brian, though did not detain him as they deemed him not to meet psychiatric hold criteria for danger to self or others, nor grave disability.

I accompany Evelyn on the drive to Meghan's home, where Brian also lives. As we park our car, a fire truck turns on its lights and sirens and speeds towards us. Evelyn mutters, "I hope that's not for [Brian]." The truck turns a corner and Evelyn breathes a sign of relief. We exit the car and Meghan greets us in her driveway. Meghan guides Evelyn and me around the house to a backyard patio, where Brian sits on a patio chair. Brian is a thin, tan, white man in his mid-20s. He is shirtless and barefoot. He wears a pair of baggy basketball shorts. He asks whether it is ok that he smokes, and Evelyn nods yes. He stretches and lights a cigarette.

Evelyn mentions the email that she received from Meghan regarding the recent 911 call and police assessment. Brian nods, though does not speak. Evelyn then asks whether Brian might sign consent forms to receive case management services from her organization. Brian looks at Evelyn quizzically. He shrugs his shoulders and nonchalantly replies, "Yeah, I'll sign."

Evelyn seems caught off guard by Brian’s ambiguous reply and nervously exclaims, “Congratulations! We are so excited for you!” She shuffles through her purse, pulls out a consent form, describes each of the services that her organization provides, and asks again for Brian’s signature.

Brian replies, “Whatever,” and signs the form. Evelyn then asks for Brian’s consent for her organization to communicate with Meghan about Brian’s case management services. Brian declines to consent. He calmly states, “My mom is dangerous.”

Evelyn and I say goodbye to Brian, walk back around the house, and return to our car. Evelyn notes that Meghan has already enrolled Brian in Medicaid and Medicare. Meghan has also obtained Social Security Disability Insurance (SSDI) and food stamps for Brian. Brian receives psychiatric medication treatment from a psychiatrist at a local clinic. Evelyn makes a plan to apply for both General Relief (GR) and Supplemental Security Income (SSI) on Brian’s behalf in order to supplement his meager income.

American Hegemonies of Psychosis and Dependency

Over the past 200 years in the United States, care provisioning for psychotic and dependent persons, like Brian, could be viewed as a succession of hegemonic orders. Hegemony is a theoretical concept with a “complicated and variable” (Williams 2015, 100) etymological history in the field of anthropology. Cultural and literary historian Raymond Williams writes that hegemony is,

> Different from IDEOLOGY (q.v.) in that it is seen to depend for its hold not only on its expression of the interests of a ruling class but also on its acceptance as ‘normal reality’ or ‘commonsense’ by those in practice subordinated to it. It thus affects thinking about REVOLUTION (q.v.) in that it stresses not only the transfer of political or economic power, but the overthrow of a specific **hegemony**: that is to say an integral form of class rule which exists not only in

> political and economic institutions and relationships but also in active forms of experience and consciousness. This can only be done, it is argued, by creating an alternative **hegemony** – a new predominant practice and consciousness […]. Thus an emphasis on **hegemony** and the **hegemonic** has come to include cultural as well as political and economic factors (Williams 2015, 100).

Philosopher Antonio Gramsci writes that hegemony entails, "The combination of force and consent, which balance each other reciprocally, without force predominating excessively over consent" (Gramsci 1971, 80). Sociologist Michael Burawoy clarifies that,

> Each political order has a hegemonic ideology, a hegemonic system of ideologies that provide a common language, discourse, and normative visions shared by the contestants in struggle […]. Alternative hegemonies emerge in moments of organic crisis, otherwise they have little support (Burawoy n.d., 5–6).

Burawoy continues, "A lot rests on the idea of consent, a knowing and willing participation of the dominated in their domination" (Burawoy n.d., 8).

In the context of mental health care, strategic alliances between family members, governments, and ultimately, taxpayers, maintain a hegemonic order that obligates certain sectors of society – families, hospitals, jails and prisons, social welfare programs – to provide for a subset of psychotic and dependent persons. Transition to an alternative hegemony of care occurs when the forces of production (i.e. economic demands) become too great for one or more sectors to bear. Transition does not necessarily occur due to the development of objectively better ways to care for dependent persons. To know the salient highlights of this hegemonic history can aid in understanding how and why persons like Brian currently depend on their families and an array of government welfare programs for their livelihoods.

In the mid-18th century, the first mental hospital in the modern sense of the word was founded in Philadelphia. At the time, factors such as increasing urbanization and merchant capitalism exerted pressures on families. Whereas dependent mentally ill persons had once been treated on family or small community-bases in preindustrial societies, such intensive care was increasingly difficult for family wage earners to provide as they spent significant portions of their workdays away from home and at factory and commercial center-based jobs (Grob 1994, 1–53; Scull 2015, 188–223). From the 1840s through the 1860s, families abandoned an escalating number of mentally ill individuals to "wretched" (Grob 1994, 46) conditions in prisons, almshouses, and the streets. Advocates like Dorothea Dix traveled nationally and spread a message of states' collective moral responsibility to care for dependent mentally ill persons. Dix advocated for the establishment of a network of long-term care institutions. By the time of her retirement in the late 19th century, 30 such state mental hospitals had been constructed across the United States (Grob 1994, 46–47). Once an emergent form of caring for dependent mentally ill persons, institutionalization was now the hegemonic foundation of mental health policy in the country.

Prior to World War II, a majority of psychiatrists would train and work in these state mental hospitals as care managers for dependent persons. Psychiatric treatment modalities at the time included electroshock, lobotomy, and physical restraint. Professional course curricula emphasized the biological nature of mental illness, and focused little on environmental and social influences. Post-War, a quorum of young psychiatrists led by a trio of Kansans – Karl and William Menninger of The Menninger Clinic fame, and Robert Felix, the eventual first director of the NIMH - advocated for the establishment of community care networks modeled after effective wartime frontline clinics. These psychiatrists spoke out against the use of electroshock and lobotomy. They studied psychoanalytic therapy and emphasized the importance of unconscious conflicts and environmental stressors in producing and sustaining mental illness (Grob 1994, 103–248; 1991, 5–156).

From the 1950s through the 1960s, a diverse set of factors then spurred what would become a large-scale, nationwide state hospital deinstitutionalization. These factors included the introduction of the antipsychotic medication thorazine in 1954, the passing of the Community Mental Health Centers Construction Act (CMHCCA) in 1963, the establishment of Medicaid and Medicare in 1965, and changes to commitment laws, such as the 1967 passing of the Lanterman-Petris-Short Act (LPS) in California which limited the extent of involuntary psychiatric commitment (and led to psychiatrists like E. Fuller Torrey describing California as "a canary in the coal mine of deinstitutionalization" (Torrey 2014, 96)). Such curtailing of involuntary psychiatric commitment was further affirmed by the 1972 federal court case Lessard vs. Schmidt, which limited involuntary commitment to cases where there was "extreme likelihood that if the person is not confined he will do immediate harm to himself or others," (Treffert 1974, 49) and by the 1975 Supreme Court case O'Connor vs. Donaldson (Oshinsky 2023). From an economic perspective, and with deinstitutionalization, state governments proceeded to offload the care costs for a large number of dependent persons onto the national government (Grob 1991, 157–304; 1994, 249–311).

In 1981, President Ronald Reagan then passed the Omnibus Budget Reconciliation Act, which effectively ended the construction of new community health centers begun under the CMHCAA. The Reagan administration packaged federal mental health spending into block grants, which were distributed to the states to use as they wished. Mental health services were increasingly privatized. With the national government withdrawing leadership, and to preserve some semblance of a care network for dependent mentally ill persons, mental health advocates successfully lobbied to shift the bulk of mental health spending to a collection of government welfare programs, chiefly SSI, SSDI, Medicaid, Medicare, and food stamps (Grob and Goldman

2006, 112–80; Harvey 2007, 1–86). Advocacy groups also promoted the notion of recovery, which entailed patients' rights to define their own mental health and to seek treatment as they saw fit (Braslow 2013). A new hegemony – the cultural, social, and political climate in which persons like Brian live – had thus coalesced.

Unfortunately, this environment of austere welfare support and moralizing advocacy did not account for the dependency needs, and associated risks of neglect, of persons like Brian. Anthropologist Sue Estroff captures this sentiment when, in the mid-1990s, she wrote,

> The American cultural ideal is that adults should have more resources than needs, more money in the bank than is spent… Most adult persons whose functioning is restricted… break this fundamental rule. Their material, functional, and often social, emotional needs are both exceptional and usually exceed their capacity to provide for them (Rhodes 1995, 120).

Unable to obtain competitive and sustained employment, persons like Brian lacked the economic agency - the power in a capitalist society like the United States - to live independently (Foucault 1978, 46). They came to constitute a lumpen proletariat, or a group of persons dependent on economically productive, and thus more powerful, members of society for basic needs, including life-sustaining factors like shelter and food (Bourgois and Schonberg 2009, 16–19, 316–20; Marx 2005). This dependence, in which family members, mental health and case management providers, and governments entities are responsible for economically unproductive, functionally-limited, and mentally ill persons, set the stage for neglect in the way of homelessness, malnutrition, and inappropriate and inadequate medical and psychiatric care.

Nationally, an estimated 10% (Torrey 2014, 159) of individuals diagnosed with serious mental illnesses thus began to lead "peripatetic lives" (123) and to

> Receive uncoordinated and disjointed mental health services. They [were] randomly rehospitalized in whatever hospital happen[ed] to have a bed available despite the fact that the staff of that hospital may have little or no information

> regarding the patient’s extensive and complicated medical and psychiatric history (154).

Psychiatric care providers could not give definitive DSM-based psychiatric diagnoses to many patients caught in this “revolving door” (Brodwin 2013, 33), as knowledge of patients’ longitudinal illness courses, a requirement for meeting DSM diagnostic criteria, were often unknown. Without diagnoses, these patients were missing “the first step toward [psychiatric] treatment” (Metzl 2009, 203). As encapsulated by psychiatrist E. Fuller Torrey,

> In 1982 Susan Sheehan created a stir when she published a book about a woman with schizophrenia who, over an 18-year period, experienced 27 separate admissions to 8 different hospitals and a total of 45 different treatment settings. Such discontinuous treatment, regarded as aberrant in 1982, is now regarded as the norm (Torrey 2014, 154).

American Culture Critique and Structural Competency

> ‘Hegemony’ goes beyond ‘culture’ […] in its insistence on relating the ‘whole social process’ to specific distributions of power and influence. To say that ‘men’ define and shape their whole lives is true only in abstraction. In any actual society there are specific inequalities in means and therefore in capacity to realize this process […] [Hegemony is] in the strongest sense a ‘culture’, but a culture which has also to be seen as the lived dominance and subordination of particular classes (Williams 1977, 108, 110).

As a theoretical concept, culture has, like hegemony, developed various anthropological connotations over time (Williams 2015, 52–53). Franz Boas adopted and articulated the culture concept for American anthropology in the early 1900s while professionalizing the field at Columbia University (Stocking Jr. 1968). He envisioned cultures as groups of diverse but interconnected individuals with collective internal orientations (e.g. ideologies, tastes). Boas developed many of the characteristics that modern anthropologists associate with the culture concept including holism, pluralism, relativism, and behavioral determinism (Brightman 1995).

Beginning in the 1950s, culture ecologists, including Leslie White, Elman Service, and Marshall Sahlins, studied

> What came to be labeled 'general evolution,' or the evolution of culture-in-general, in terms of stages of social complexity and technological advancement. These stages were subsequently refined [...] into the famous bands-tribes-chiefdoms-states scheme. The evolutionary mechanisms [...] derived from more or less fortuitous events: technological inventions that allowed for the greater 'capture of energy,' and population growth (and perhaps warfare and conquest) that stimulated the development of more complex forms of social/political organization and coordination (Ortner 1984, 132).

In the 1960s, structural anthropologists including Claude Lévi-Strauss then

> Argued that the seemingly bewildering variety of social and cultural phenomena could be rendered intelligible by demonstrating the shared relationships of those phenomena to a few simple underlying principles. [Lévi-Strauss] sought to establish the universal grammar of culture, the ways in which units of cultural discourse are created (by the principle of binary opposition), and the rules according to which the units (pairs of opposed terms) are arranged and combined to produce the actual cultural productions (myths, marriage rules, totemic clan arrangements, and the like) that anthropologists record (135).

In the 1960s and into the 1970s, symbolic anthropologists including Clifford Geertz and Victor Turner, in turn, advocated that "culture was embodied in public, observable symbols" (132).

By the mid-1980s, however, some leading anthropologists began to concertedly debate the theoretical usefulness of the culture concept. In 1986, James Clifford edited the influential text *Writing Culture.* In the introduction to the book, Clifford writes, "If 'culture' is not an object to be described, neither is it a unified corpus of symbols and meanings that can be definitively interpreted. Culture is contested, temporal, and emergent" (Clifford 1986, 19). He continues, "Post-modernism [...] is a general condition of multicultural life demanding new forms of inventiveness and subtlety from a fully reflexive ethnography" (22-23). Clifford espoused a view that culture is a productive tool for highlighting the dynamic and relativistic ways in which groups of humans interact. However, Clifford also emphasized that the culture concept might not adequately account for the political and economic forces that impact human behavior (Brightman 1995).

Five years after the publication of *Writing Culture*, anthropologist Lila Abu-Lughod argued that culture did not do justice to the individual, intersectional, and subjective realities of lived human experience. She wrote

> I will argue that 'culture' operates in anthropological discourse to enforce separations that inevitably carry a sense of hierarchy. Therefore, anthropologists should now pursue, without exaggerated hopes for the power of their texts to change the world, a variety of strategies for writing *against* culture (Abu-Lughod 1991, 137–38).

Abu-Lughod reasoned that the culture concept carried indelible connotations of a hierarchical divide between the knowing academic and the cultured other. She also stressed that the concept belied an ignorance of racial, gender, and class-based variables that overwhelmingly impacted individuals' lives (Brightman 1995).

In the 1990s, anthropologists Akhil Gupta and James Ferguson furthered these culture critique arguments with their problematization of commonly held associations between culture and place. Gupta and Ferguson write that a,

> Set of problems raised by the implicit mapping of cultures onto places is to account for cultural differences *within* a locality. 'Multiculturalism' is both a feeble acknowledgement of the fact that cultures have lost their moorings in definite places and an attempt to subsume this plurality of cultures within the framework of a national identity. Similarly, the idea of 'subcultures' attempts to preserve the idea of distinct 'cultures' while acknowledging the relation of different cultures to a dominant culture within the same geographical and territorial space. Conventional accounts of ethnicity, even when used to describe cultural differences in settings where people from different regions live side by side, rely on an unproblematic link between identity and place. Although such concepts are suggestive because they endeavor to stretch the naturalized association of culture with place, they fail to interrogate this assumption in a truly fundamental manner. We need to ask how to deal with cultural difference while abandoning received ideas of (localized) culture (Gupta and Ferguson 1992, 7)

They continue,

> What is needed, then, is more than a ready ear and a deft editorial hand to capture and orchestrate the voices of ‘others’; what is needed is a willingness to interrogate, politically and historically, the apparent ‘given’ of a world in the first place divided into ‘ourselves’ and ‘others.’ A first step on this road is to move beyond naturalized conceptions of spatialized ‘cultures’ and to explore instead the production of difference within common, shared, and connected spaces (Gupta and Ferguson 1992, 16).

Using a classic and somewhat anachronistic Boasian understanding of culture, and one notably devoid of the aforementioned culture critiques, in the mid-1990s, North American medical schools began to incorporate a type of culture training – framed in terms of ‘cultural competency’ – into their curricula in an effort to improve delivery of care to underserved populations (Metzl and Hansen 2014). This training aimed to “teach medical students and house staff how to effectively and respectfully deliver health care to the increasingly diverse populations of the United States” (Tervalon and Murray-García 1998, 117). Trainees were taught how to better understand the needs of “immigrants, refugees, and others on the sociocultural margin” (Gregg and Saha 2006, 542), as well as how to recognize cross-cultural illness expressions. The culture concept, as used in these training contexts, largely connoted static, bounded, and inclusive groups with collective clinical behaviors that reflected their shared nationalities, languages, and/or ethnicities (Kleinman and Benson 2006).

In the early 2010s, physicians including psychiatrists Helena Hansen and Jonathan Metzl, then borrowed from their culture critique forebears like Clifford, Abu-Lughod, Gupta, and Ferguson to “rearticulat[e] ‘cultural’ formulations in structural terms” (Metzl and Hansen 2014, 126). These proponents translated a Marxist perspective from the sub-field of critical medical anthropology to medical training. Such a perspective, as seen in the work of anthropologists like Paul Farmer, Arthur Kleinman, and Merrill Singer, stressed a relationship between clinical symptoms and power (i.e. political oppression and economic inequality) (Singer 1990; Farmer

2004; Kleinman and Benson 2006). Structural competency training, its proponents argued, could help physicians to recognize, and ideally address, systemic inequities – or structural vulnerabilities - in areas such as healthcare coverage and pharmaceutical pricing, that ultimately made individuals and populations sick (Metzl and Hansen 2014; Quesada, Hart, and Bourgois 2011).

This type of applied structural stance, in which anthropological theory and methodology are employed to elucidate health inequalities, and clinical knowledge is used to propose care system change to alleviate these inequalities, is the backbone of this dissertation. Thematically, I focus on the interplay between psychotic mental illness and dependency. I examine how psychosis can impact functioning, in particular a person's ability to provide for core survival needs like food, shelter, and safety. I utilize participant observation and case study to illustrate how society fails to address unfilled core dependency needs, and to reveal the dire consequences when such needs go unmet. I conclude by highlighting interventions that explicitly address structural determinants and that might prevent some dependent psychotic individuals from falling through the cracks of the social welfare system (Bromley et al. 2015)

Government-based psychiatric treatment programs such as Assisted Outpatient Treatment (AOT), on which I completed 2 years of ethnographic fieldwork in preparation for writing this dissertation, provide extraordinary perspectives on the dependency needs of persons like Brian. The Assisted Outpatient Treatment (AOT) Demonstration Project Act, otherwise known as Laura's Law, is a law passed in 2002 as part of the State of California's Assembly Bill 1421. AOT-LA – Los Angeles' AOT program – was implemented in 2014 and launched in 2015. Per the Los Angeles County Department of Mental Health (LACDMH), the

> AOT-LA program serves seriously mentally ill individuals who are at substantial risk of deterioration and/or detention […] as a direct result of poor psychiatric

> treatment compliance. The program outreaches to these individuals in an effort to engage them in voluntary treatment. If the individual continues to decline treatment, the program may elect to petition the individual into court ordered treatment […] To qualify for AOT-LA services, [a] candidate must meet all criteria below:
>
> - 18 years of age or older
> - Seriously mentally ill
> - Unlikely to survive safely in the community without supervision
> - Have a history of non-compliance with treatment [that] has resulted in either:
>   - Two or more hospitalizations or incarcerations within the last 36 months; or
>   - Within the last 48 months, one or more acts and/or attempts to cause serious physical harm to self and/or others
> - Substantially deteriorating
> - Likely to become gravely disabled or seriously harm themselves or others without treatment
> - Failing to engage in available treatment
> - Likely to benefit from AOT-LA services
>
> (Los Angeles County Department of Mental Health n.d.).

AOT-LA largely aims to enroll clients like Brian with histories of psychotic symptomatology. These are individuals who have been admitted to hospitals, jails, and/or prisons in the recent past. At the time of AOT outreach, they live in a variety of settings including streets, shelters, homes, and institutions. Many cannot rely on family financial support for basic needs and mental health treatment. As a whole, AOT clients represent a "subset of seriously mentally ill individuals […] who are repeatedly rehospitalized, become homeless, are regularly victimized, and end up in jails and prisons" (Torrey 2014, 159).

Chapter 2

Ethnographic Interlude

A week after first meeting Brian, Evelyn and I return to complete a case management intake interview. As Evelyn and I walk to Meghan's home, we notice Meghan and Brian standing outside. Meghan sprays water on a freshly planted garden and Brian stands and watches. Brian approaches Evelyn and states, "My girlfriend just died. The one who I had been chasing." Evelyn consoles Brian.

Meghan, who continues to water the garden, shakes her head, leans towards me, and whispers, "No one died. That's just his delusions." Evelyn asks Brian if he would still be ok with completing the intake interview despite the circumstances. Brian agrees to talk. He leads us around the home to the backyard patio, where we arrange seats in the shade of a table-mounted umbrella. Brian slumps back in his chair and closes his eyes. Evelyn asks whether Brian would like to talk more about his girlfriend's death. Evelyn asks what the girlfriend was like and how she died.

Brian motions as if drinking from an invisible cup. He then states, "She was always doing this with her hands." He makes a rubbing motion between his index finger and thumb. He begins to cry, grabs a glass pipe, and remarks, "I really need to smoke some weed." Evelyn asks what weed does for Brian. He states that the drug allows him to reach a higher plane of thinking. Evelyn says that she cannot prevent Brian from smoking weed. However, she also cannot be present when he does so. Brian puts the pipe down and asks Evelyn whether she finds him charming. Before Evelyn can reply, Brian stands up, says that he has a hat that he wants to show us, and runs inside the house.

Meghan approaches the patio and briefly joins Evelyn and me at the table. Meghan exasperatingly states, “I am sick of this. I can’t do it anymore. There is so much enabling going on here. He [Brian] is always saying this is his house. This is my house and he just stays here!”

Brian returns to the patio and Meghan departs. Brian wears a white fedora hat and he smiles gregariously. He admits to having just smoked weed. He sits down at the table and says that he is now prepared to answer questions.

Evelyn begins by asking Brian about his educational history. Brian replies, “I dropped out in 7th grade. Not even a high school drop out.” He stands up and dances back-and-forth for a few steps. He then walks away from the table, briefly disappears around the side of the house, and returns. Evelyn asks Brian to further clarify his educational history. Brian replies that he technically,

> Completed 10th grade because of No Child Left Behind. They keep pushing you through grades depending on your age no matter what. I have always been good at reading but have never been any good at math. Don’t put it on paper, but if I did want to go to school, I would go all the way for a PhD. All the way! But I don’t want to go back to school.

Evelyn then asks Brian about his housing history, including whether he has ever experienced homelessness. Brian responds, “I have been on the streets since 7th grade.”

Evelyn questions, “But you always come home to sleep, correct?” Brian acknowledges that this is true.

Evelyn then asks Brian about his medical history. He replies, “I have lung cancer on the right side.” Evelyn asks for further details regarding the cancer diagnosis and treatment. Brian replies, “I know because I can feel it. I smoke a lot of cigarettes and that is probably why.”

Evelyn asks about Brian’s family psychiatric history. Brian replies that his mother is “abusive” and an “alcoholic” who drinks vodka nightly.

Evelyn asks about Brian's drug history. Brian laughs and replies, "I drink a lot of alcohol. I can drink 30 bottles in a day." He also smokes marijuana regularly and has used heroin in the past.

Evelyn asks about Brian's current prescription medications. Brian notes, "I am on 10 milligrams of Haldol, but I only take 5 per day. I also got my Xanax prescription raised to 3 milligrams per day […] I am 5% better on Haldol. But on Xanax, I'm 30% better."

Evelyn remarks that she needs to end the interview for today to leave time to see another client. Evelyn and I say goodbye to Brian and walk back around the house. As we proceed down the driveway on our way back to our car, we hear Meghan call to us. We turn around and spot Meghan, who sits on the floor of her garage. We walk up to the garage to speak with her. Meghan sits amidst piles of bills and insurance paperwork. She seems to have converted the garage into a makeshift office. Against one wall stands a plastic card table, which serves as her desk. On another wall, she has fixed a pin board, which is full of papers that flutter in the breeze. Near the board stands a large bookcase filled with binders for "insurance" and "medical care."

Meghan stands and explains that she is trying to organize all of Brian's medicolegal paperwork. She states, "I've done all of his paperwork. Medicare, Medicaid, Social Security, disability, you know getting him into the AOT, copies of hospital records. I do all of that." She continues, "I take care of all his doctor's appointments. I pick up his meds. I dispense his meds." Evelyn asks how Meghan, herself, is doing. Meghan shares a series of worries. She states,

> I have just had it. I have a hard time getting through the day. I don't want to get up in the morning. It's not because I am tired, I just don't want to keep going through this. Some days Brian and Simone [Brian's sister, who has been diagnosed with schizoaffective disorder, bipolar type and who takes the antipsychotic medication, clozapine] are fine. Other days, Brian is raging at me or standing on the roof saying that the world is going to end. Simone is doing ok now. She gets disability and social security, but that only amounts to $600

> something per month. She does help around the house, though. And, she pays for her own gas. Brian doesn't do anything.

Evelyn asks whether Meghan, herself, has considered seeing a therapist. Meghan replies,

> I went to Kaiser and filled out this form and they said that my stress level wasn't high enough to qualify for help. I take Zoloft, though. I really don't mind taking it. I try to set a good example for Brian. He is always saying that he doesn't want to take his Haldol and I tell him that I am taking my psychiatric meds. Sometimes, I forget to take it for a while. I'll have a bad day here or there and remember, 'Oh, I wasn't taking my Zoloft.' Then I'll start taking it again.

Meghan continues,

> Miserable and suicidal. Those are his [Brian's] words when he takes the Haldol. But at the same time, Haldol is the only thing that works for him. I was trying to get him genetic testing for compatibility for psychotropic drugs with GeneSight [genetic testing company] and they are covered [by Brian's health insurance]. Well certain places are covered with Medicare. I told him about it, trying to coax him into doing it so we can see what medications would be most beneficial and he's refusing to do that. [I am trying to provide] some alternatives so he can have some say or at least see some scientific basis for what [medication] works […]. He tried [Risperdal], which he absolutely hates. He tried Invega. That he did for 4-5 days. He had Abilify for a couple days. He had Lithium at one point. [He tries medications] for a few days and never gives [them] enough time to be effective or for the initial side effects to wear off.

Evelyn asks whether Meghan could use some help around the house, perhaps from a home health care provider. Meghan notes that she, herself, applied to be a home health care provider for Brian, a job that would have paid her around $1,220 per month. However, as Meghan was not truthful regarding her previous work history in the job interview process, the application was denied. Evelyn asks Meghan to further clarify what happened during the job interview, though Meghan does not elaborate. Meghan notes that she still has a real estate license, though has not worked in the field for some time, as she has been occupied with caring for her two adult children. Meghan separated from Jake, Brian's father, around 20 years ago. Since then, Jake, who lives in Florida and works as a bondsman, has been what Meghan describes as a "Disneyland dad." Jake takes Brian on occasional trips, though does not assume responsibility for Brian's upbringing and daily wellbeing.

Evelyn asks how Meghan decompresses. Meghan replies, "Yeah, when Brian is sleeping I can get away for a few hours. I like to play cards with my girlfriends." Meghan then talks about her wish to go on a church service trip to Nepal. She worries that Brian's mental health might be too tenuous for her to do so. She also worries that Brian might be progressing towards another 5150 (72-hour, involuntary psychiatric hold for danger to self or others, or grave disability). She states,

> He [Brian] is just getting worse. We have been through this already with Simone. She would be placed on holds all the time. We tried to shield Brian from it. She was held 13 times. Brian is going on his 9th hold [in 3 years]. Between the two of them, they will have had 22 holds and 17 hospitalizations.

Meghan notes that Brian first exhibited delusional thinking around 3 years ago. She chastises herself for not further investigating what, in hindsight, were prodromal psychotic symptoms. Meghan exclaims that she, "Didn't think that lightning [psychosis] could strike twice," especially since her children have two different fathers.

A month after first meeting Brian, Evelyn and I return to Meghan's home to visit him. We arrive to again find Meghan gardening in the front yard. Meghan, who appears exasperated, updates us that Brian stopped taking his prescribed Haldol. He also made plans to move from Los Angeles to Las Vegas. Evelyn and I thank Meghan for the update. We walk around to the back patio, where we find Brian. He smiles and greets us. We arrange chairs around the patio table and sit down to talk.

Brian enthusiastically shares his plan to move to Las Vegas and to work at a game store that his father owns and operates. Evelyn asks how Brian plans to pay for rent and food. Brian says that he is confident that the SSI application, which Meghan recently submitted on his behalf, will go through. Apart from working at the game store, he also plans to "do stuff under the table." Evelyn asks why Brian wishes to leave Los Angeles. Brian shares that he does not find Meghan's home to be a "mentally and emotionally therapeutic place."

Evelyn asks Brian about the state of his mental health. Brian confirms that he has not taken Haldol for a week. While taking the medication, he says that he felt "suicidal and crappy." Since discontinuing it, he "feels great." He recently started taking Zoloft, an antidepressant, which he says makes him feel good. He continues to take Xanax daily for anxiety. He says that he is sleeping well. He plans to go to a concert with friends over the upcoming weekend.

Evelyn asks Brian to concretely lay out his plans, including his options should the move to Las Vegas not work out as planned. Brian repeatedly lights and extinguishes a cigarette as he thinks. He concludes that Plan A is to move to Las Vegas, find an apartment, and work at the game shop. Plan B is to either stay in Los Angeles with his mother or move to Florida, where his father owns a home. Plan C is to move to Denver, where one of his friends recently moved, and work in a restaurant. Evelyn asks whether Brian plans to see a psychiatrist or therapist in Las Vegas. Brian says that he does not. Evelyn says that she is sad to see Brian go, but that she wishes him the best. Evelyn and I depart.

Space, Subjectivity, and Psychosis

Despite social scientists', as well as interested clinical psychiatrists', attempts to keep social factors such as gender, race, "kinship, class, personhood, poverty, [and] meaning" (Luhrmann and Marrow 2016, 25) at the fore of mental health research, a bulk of federally funded research moneys currently focuses on neuroscientific questions of emotion, behavior, and cognition (Torrey et al. 2021; Makari 2023). As noted by sociologist and historian of psychiatry, Andrew Scull,

> Patients and their families now look to their doctors for the magic potions that will produce better living through chemistry. Those assurances may yet prove to have a solid and durable foundation, though at present they rest on faith more than science. Or perhaps they will not. More likely they may be only be part of the story, and in that case, the social and the psychological dimensions of mental illness may well have received a premature burial (Scull 2015, 380).

A victim of this burial has been investigation into the illness-altering spaces in which dependent and seriously mentally ill persons live. Persons like Brian spend large portions of their lives in some form of treatment space, including clinics, hospitals, and emergency rooms. Yet, there has been no concerted effort across psychiatry and the social sciences to theoretically and comprehensively make sense of what anthropologist Kim Hopper describes as "the institutional circuit" (Hopper et al. 1997, 659), or the modern-day, dependent and seriously mentally ill person's journey of what anthropologists T.M. Luhrmann and Jocelyn Marrow describe as "nomadic squalor between the homeless shelter, supported housing, inpatient hospitalization, and jail" (Luhrmann and Marrow 2016, 157–58) in the United States.

From the 1950s through the 1970s, the anti-psychiatry movement, led by a mélange of psychiatrists and social scientists including Erving Goffman, Franco Basaglia, Thomas Szasz, and R.D. Laing produced a significant amount of critical, moralizing literature that "sought to reveal the construction of psychiatric truth through coercive power, both to liberate patients from their institutional domination and to develop new therapeutic avenues to the truth of madness" (Davis 2012, 58; Goffman 1961; Basaglia 1987; Szasz 2010; Laing 1990). This group was particularly interested in the ways in which institutions, primarily state mental hospitals at the time, shaped mentally ill persons' behaviors. Philosopher Michel Foucault highlighted this spatial focus when he stated, "At the heart of antipsychiatry, [is] the struggle with, in, and against the institution" (Foucault 1994a, 47). While mental health spaces have subsequently been theorized, albeit largely as separate entities, in the recent anthropology literature, and while the institutional circuit has been identified, what is lacking is a theorization of these spaces as a total set to see the effects of their conjunctions and disjunctions (Estroff 1981; Luhrmann 2000; Biehl 2013; Brodwin 2013; Carr 2011; Cohen 1998; Davis 2012; Desjarlais 1997; Hopper 2003; Goffman 1961; Janis H. Jenkins 2015; Myers 2015; Rhodes 1995; 2004; Garcia 2010).

Serious mental illness is not managed at the margins of society so much as in a "vortex of public institutions, psychiatry, law, and community" (Biehl 2013, 252) that dictates the contingencies - or the welfare, treatment, and care possibilities - available to seriously mentally ill individuals. The sheer complexity of this vortex hinders diagnostic and treatment efforts on the part of providers. Seriously mentally ill individuals can move through so many different treatment settings in their lives that questions as to the impact of a specific institution, policy, or practice on their mental health become incidental. At some point in a seriously mentally ill person's life, attempts to "tease out the specifics of her bodily or mental condition" (Biehl 2013, 193) become futile. "Too many threads" of diagnoses, treatments, and symptoms become "knotted together" and "the knots, so to speak, bec[o]me the focus" (Biehl 2013, 193).

Today, many seriously mentally ill individuals, particularly those diagnosed with schizophrenia spectrum disorders and those with few economic means, do not hold one housing status for their entire lives. Instead, they wander the institutional and domestic circuit. Along the way, they are made into new people by each space. This process of space-dependent person making, or subjectivity forming, occurs throughout their lives. Although far from determining each persons' mental illness, personality, or orientation to the world (i.e. this is not a "romantic nonsense" (Scull 2015, 11) argument that mental illness is purely socially constructed and that behavior is completely non-agentive), the spaces (hospitals, jails and prisons, houses, and streets) that dependent and seriously mentally ill persons pass through do produce certain manifestations of mental illness. This production echoes anthropologist João Biehl's notion of "social psychosis," (Biehl 2013, 106) or the ways in which "novel conjunctions of kinship, public institutions, psychiatry, and medication work, if not to make people psychotic, then to give a certain form and value to their experience as psychotic," (106) and "to bring into view the relations that [exist] between [their] subjectivity and social, familial, and medical identifications" (315).

This is an initial attempt to theoretically describe and ethnographically illustrate the decentralized, multi-spatial, and complex institutional circuit in which many dependent and seriously mentally ill individuals live. I return to the anti-psychiatry focus on space, not to censure institutions, but with the intent to explore space as an overarching, organizing frame to conceptualize the places in which these individuals live, interact with kin and providers, exhibit behaviors, and ultimately develop mental illness subjectivities. I draw upon foundational, critical, and historical literature across the social sciences and psychiatry to show the ways in which mental illness subjectivities are intricately linked to questions of space. I focus on three general categories of space: home, institution, and the street. I discuss the unique, subjectivity-influencing factors of each. I contend that it is important not to shy away from an analysis of the complexity of today's mental health system. Rather than writing off space and its effects on mental illness as incomprehensible side shows to 'real' psychiatric issues of symptomatology, diagnosis, and pharmacology, I propose bringing questions of space to the fore in order to illustrate the productive power of the institutional circuit.

Initial Theoretical Considerations. In texts such as *The Elementary Forms of Religious Life, Primitive Classification,* and *Culture and Communication,* social scientists Émile Durkheim, Marcel Mauss, and Edmund Leach explore the concept of the cultural 'category' (Durkheim 1995; Durkheim and Mauss 1963; Leach 1976). They argue that space, time, class, and causality are collectively and contextually defined categories necessary for logical thought within a given society. The category of space comprises all of the possible places that a given society can conceive. Mentally ill space, specifically, can therefore be thought of as all of the institutions, homes, shelters, streets, and encampments in which the seriously mentally ill might live.

In her foundational ethnography *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community*, Estroff highlights the importance of understanding seriously mentally ill persons' "use and perception of space because the spatial dimension provides significant information and messages to people about themselves and their relations with others" (Estroff 1981, 53). Anthropologist Edward Hall seconds this assertion when he notes that "man's feeling about being properly oriented in space runs deep. Such knowledge is ultimately linked to survival and sanity. To be disoriented in space is to be psychotic" (Hall 1966, 105)

Seriously mentally ill individuals not only move from space-to-space physically along the institutional circuit, but they also do so along temporal trajectories. Time reveals much about the spatial aspects of the institutional circuit. Personal experiences in institutions, homes, and streets accumulate over time to comprise a subjectivity, or a truth of who the person is in their local world. This is more than a habitus, or a durable, adaptable inclination to act in certain ways shaped by the norms of the world in which one lives (Bourdieu 2000, 128–63). The seriously mentally ill person's subjectivity, her self, is a product of her spatial and temporal moves through the institutional circuit. It emerges as "all the identifications that can be formed by, discovered in, or attributed to" (Biehl 2013, 137) her as a person, including her thoughts, behaviors, and mental illness symptoms. It forms under the influence of the words and actions of providers, as well as the divisions and restraints that define the spaces of the institutional circuit. Many of these spatially-based factors involve some form of subjugation of the seriously mentally ill person. Feminist theorist Judith Butler, following Foucault, "calls this the paradox of *subjectivation*, insomuch as the very processes and conditions that secure a subject's subordination are also the means by which she becomes a self-conscious identity and agent" (Mahmood 2001, 210)

Mental Illness in the Institution. Institutions such as jails, prisons, and hospitals house many seriously mentally ill individuals. Deemed a danger to self or others and/or unable to care for themselves, these individuals are removed from society and placed in a "black box within a black box" (Rhodes 2004, 3) that sequesters them from public view. At the heart of these totalizing institutions is the attempt to differentiate madness from reason (Rhodes 2004). Diagnosis and treatment are made all the more difficult by the stressors inherent within the institutional environments themselves (Goffman 1961).

Philosopher Giorgio Agamben describes camps as totalizing institutions born out of "state[s] of exception" (Agamben 1998, 167). Camps serve to differentiate insiders from outsiders. In regards to mental institutions, disruptive behavior, whether violent or maladaptive, distinguishes the "difficult, complex, 'extraordinary'" (Foucault 1994b, 42) camp subjects. Hospitals, jails, and prisons all fulfill integral camp roles on the institutional circuit by detaining mentally ill persons.

Anti-psychiatrists, including Erving Goffman and Franco Basaglia, were particularly interested in the institutional shaping of behavior. They argued for near-direct associations between restrictive and abusive state mental hospital practices and mental illness symptoms (Goffman 1961; Basaglia 1987). Goffman based his critique of the state mental hospital system on the observation that unique individuals with disparate symptomatology, whom he described as "perhaps the most obstinate diversity of human materials that can be brought together by society," (Goffman 1961, 129) enter state hospitals only to leave with similar traits to one another. He wrote that state hospital patients

> Vary widely in the kind and degree of illness that a psychiatrist would impute to them, and in the attributes by which laymen would describe them. But once started on the way, they are confronted by some importantly similar circumstances and respond to these in some importantly similar ways (129).

To Goffman, behaviors that looked pathological to outsiders were often understandable responses to the state hospital experience. Specifically, Goffman described four tactics that hospital patients used to be heard, have their needs met, and/or insulate themselves from the hospital environment. These included withdrawal/regression (isolating oneself), intransigence (overtly challenging institutional rules), colonization (striving to appease staff), and playing it cool (opportunistically using a combination of the above tactics).

Franco Basaglia founded the Italian anti-institutional movement on the premise "that the real source of patient violence and aggression was not illness but rather sickening and perverse family, social, and institutional relations" (Basaglia 1987, 55). Basaglia argued that intrusive, objectifying hospital environments, in which patients were constantly watched and granted scant freedom and responsibility, produced "forbidden act" (57-58) violent behaviors. Basaglia writes,

> The logic of the asylum reproduces the very behavior it is supposedly mobilized at every turn to prevent. From the patient's perspective, what else is the implicit message conveyed by locked doors, barred windows, keys, and physical restraints

> if not the taunting dare to escape? So, too, the constant overprediction of the mental patient's dangerousness to self or to others can elicit suicide or murder as the only possible autonomous act, as the only affirmation of existence available to the damned […]. The shaft of light from an open door, the unguarded room, the half-open window, the knife left lying about, all present an open invitation to destruction […] When there are no alternatives and no possibility of autonomous behavior, the only future is death. Death presents itself as a rejection of an unbearable life; as a protest against objectification; as an illusion of freedom; as, in short, the only possible plan. It is far too easy to see this death as part of the nature of the illness, as traditional psychiatry would have us believe. In this context, every action that in some way breaks the iron grip of the institutional regime gives an illusion of freedom (57-58, 87-90).

For Basaglia, violence-laden patient subjectivities, including suicidal tendencies, were understandable outcomes of their threatening institutional surroundings.

Lawyer Elyn Saks provides first-person accounts of undergoing physical and chemical restraint in inpatient hospital settings in her memoir *The Center Cannot Hold: My Journey Through Madness*. She recalls feeling "small and helpless," and "unlikely (and unable) to hurt anyone" (Saks 2015, 155) prior to and while being restrained. Saks describes one illustrative emergency room instance in which she wielded a large nail for protection and refused to give the nail to hospital staff. She writes,

> The Doctor and his whole team of ER goons swoop down, grab me, lift me high out of the chair, and slam me down on a nearby bed with such force I see stars. Then they bind both my legs and both my arms to the metal bed with thick leather straps. A sound comes out of me that I've never heard before – half-groan, half-scream, marginally human, and all terror. Then the sound comes out of me again, forced from somewhere deep inside my belly and scraping my throat raw […] With my arms and legs pinioned to a metal bed, my consciousness collapsing into a puddle, and no one paying attention to the alarms I've been trying to raise, there is finally nothing further to be done (3-4).

She further describes how, in future hospital settings, she monitored for and thwarted restraint attempts by listening for "forbidding" (60) and "stern" tones in the voices of her psychiatrists and keeping an eye "in the direction of the door" at all times as a potential escape route.

While Saks concedes that she is mentally ill and in need of intensive hospital treatment, this instance, and her subsequent vigilance toward hospitalization, illustrate the ways in which force, in the form of physical and pharmaceutical restraints, shapes patient subjectivity. When Saks is most profoundly impacted - when she wields a nail for protection and feels small and afraid - she is bound, drugged, and isolated. As also noted by anthropologist Lorna Rhodes, emergency scenarios in institutional settings tend to entail unreflexive action. Staff members swiftly use available and justifiable means to solve crises (Rhodes 1995, 37–38). These means often do not take into account Goffman's and Basaglia's warnings of the ways in which objectified mentally ill patients might engage in tactical and/or forbidden acts in reaction to threatening institutional environments. To hospital staff, Saks brandishes a nail and locates escape routes because she is mentally ill, not because she is trying to achieve some semblance of freedom from the straits she is in. Per her own account, however, Saks' behavior reflects the threatening institution in which she finds herself.

In her ethnography *Total Confinement: Madness and Reason in the Maximum Security Prison*, Rhodes focuses on the prison paradox that "the tighter control becomes, the more problematic are the effects it precipitates" (Rhodes 2004, 4). Nowhere is this more obvious than in solitary confinement. Here, "disturbed mental states are addressed by imposing conditions that further disturb the mind" (59-60). Seriously ill mentally ill individuals placed in solitary confinement can become almost inconceivably disconnected from reality. Extreme behaviors "unknown in the outside world," (35) such as feces smearing and tossing, can become commonplace.

Like restraint, isolation involves the use of force to subdue and detain patients. The extreme behaviors that it produces, such as feces smearing and throwing, can be products of the environment as well as the persons' mental illness. The lack of available resources and dearth of social contacts present in solitary confinement shape the subjectivity of the isolated, seriously mentally ill individual. Goffman describes the ways in which extreme material deprivation, like that seen in hospital, jail, and prison solitary units, paradoxically permits patients a wealth of freedom in insulting staff. He writes, "inmates on these wards have very little reputation or rights to lose and can therefore take certain liberties" (Goffman 1961, 166) Not only are these patients materially deprived, they are also socially isolated. The little human contact that they have comes from staff interaction, most commonly during meal times. Through "rise-getting" (58-59) tactics, isolated patients induce staff reactions.

In isolated settings, and/or with no other objects to use to elicit attention, feces can become a tool of choice. What seems to be an obvious symptom of mental illness can also reflect the ward's socially and materially depraved environment. As described by anthropologist Begoña Aretxaga in her study of prisons during The Troubles,

> From 1978 to 1981 IRA [Irish Rebublican Army] and Irish Liberation Army (INLA) male prisoners in Northern Ireland undertook an extraordinary form of protest against prison authorities and the British government. They refused to leave their cells either to wash or to use the toilets, living instead in the midst of their own dirt and body waste. In 1980 they were joined by their female comrades, thus adding menstrual blood to the horrendous excretal imagery of the protest. Unlike the hunger strike on which the prisoners would embark in 1981, the Dirty Protest had no precedent in the existing political culture. This action, which resonated with notions of savagery, irrationality, and madness, was shocking and largely incomprehensible to the public in Ireland and Britain (Aretxaga 1995, 124).

Mental Illness in the Home. Family members manage mental illness and its associated economic costs within the home. Here, the mentally ill individual lives as a member of a social unit consisting of disparate players with often conflicting personalities and goals. Kinship, "that ‘diffuse, enduring solidarity,’” (Hopper 2003, 40) obligates family members to care for dependent persons. Unable to contribute significantly to household budgets and tasks, many seriously mentally ill individuals live at the whim of kinship ties and risk being pushed out of the home should their emotional and economic burdens become too great for the family to collectively handle.

Psychotic symptoms often do not manifest in a constant way, but rather in episodes. Psychosis tends to ebb and flow in time, with breaks of hallucinations and delusions occurring amidst periods of stasis. Anthropologist Mary Douglas’ descriptions of the house as a place with a capacity for memory or anticipation captures ways in which the kinship unit senses this historicity and recurrence and monitors for psychotic breaks. Douglas theorizes that home dwellers live by unique time standards. She observes that these standards can manifest as a sort of “memory or anticipation” (Douglas 1991, 294) of future events, like how the “response to the memory of severe winters is translated into a capacity for storage, storm windows, and extra blankets.” This talk of home, memory, and storms bears similarities to the ways in which families describe the often slow and setback-laden process of caring for seriously mentally ill family members.

Douglas also describes the ways in which a family member might commit “offenses against the collectivity” (Douglas 1991, 300) by not following unwritten rules of the house. These “spoliation[s] of the commons” (301) include failing to contribute money or time to efforts that improve the family unit’s well-being, as well as failing to show up to family gatherings. Douglas writes,

> It is generally well recognized that the main contribution of members to the collective good is to be physically present at its assemblies. An act of presence is a public service. Absence is to be deplored. Perhaps the most subversive attack on the home is to be present physically without joining in its multiple coordinations.

> To leave erratically, without saying where or for how long, to come back and go upstairs without greeting, these lapses are recognized as spoliation of the commons.

During fieldwork with Brian, his sister Simone, and his mother Meghan, I often observed Douglas's home-based themes of memory and spoliation. Simone took her psychiatric medications regularly, worked outside the home, and had a cordial and steady relationship with Meghan. Brian unreliably took his psychiatric medications, was unemployed, and was hospitalized for psychotic episodes on approximately a monthly basis. Even when Brian took his medications, Meghan vigilantly prepared for the inevitable. Given the seemingly inescapable repetitiveness of Brian's psychotic exacerbations, Meghan was stuck in a recurrent cycle of preparation. She frequently updated a lengthy document containing Brian's psychiatric history. She printed off copies of this document and gave it to the police officers, social workers, and physicians in charge of Brian's care. She hid kitchen knives and other potentially dangerous household items in order to ensure that Brian could not seriously injure himself or someone else. She was always anticipating and preparing her home for the next storm.

Spoliation of the commons was readily apparent in Meghan's home. Brian did not contribute monetarily to his family's wellbeing and spent most of his home life apart from other family members. Whether due to disinterest, mental instability, and/or lack of time given his repeated psychotic breaks and hospital trips, he did not hold a job nor contribute substantially to household chores. Not only did he fail to contribute to the family's livelihood, he depended on Meghan's time and money. Meghan transported Brian to psychiatry appointments and shopped for Brian's clothes and groceries, amongst other tasks.

The family home is the locus of treatment and care for many seriously mentally ill individuals. Interactions such as the above between Meghan and Brian, where family members try to cope with the realities of living with seriously mentally ill kin, are daily occurrences in many homes. However, not every family has a member like Meghan, who gives of her time and money to provide treatment and care. Some families rely on tactics of aggression and exclusion towards mentally ill kin. These hostile home environments can have significant impacts on a seriously mentally ill person's subjectivity.

The concept of 'expressed emotion' captures the ways in which family members' negative comments and actions impact illness trajectories. When excessive criticism, rejection, and other aggressions are directed toward mentally ill individuals in home settings, these individuals are more likely to clinically relapse (Bebbington and Kuipers 1994). Anthropologist Janis Jenkins illustrates the clinical effects of expressed emotion through ethnographic case studies in her book *Extraordinary Conditions: Culture and Experience in Mental Illness* (Janis H. Jenkins 2015, 71–138). Jenkins describes a patient named Sebastián, who receives psychiatric hospitalization and outpatient treatment at the UCLA Semel Institute. When not hospitalized, Sebastián lives at home with a supportive mother and a controlling, abusive father. Sebastián's father harasses Sebastián for fabricating his mental illness symptoms and for depleting household resources. In his father's eyes, Sebastián's behavior constitutes a spoliation of the commons.

To his doctors, Sebastián describes bouts of taunting and demanding auditory hallucinations from God. These hallucinations so closely mirror the abuses that Sebastián endures from his father at home that Jenkins writes, "Meaning and experience are anything but a matter of happenstance […] Sebastián's father's emotional tone of harshness and control seized Sebastián's unconscious psychological processes and reproduced that dynamic in the formation and experience of his symptoms" (Janis H. Jenkins 2015, 82, 91) Jenkins leaves little doubt that the excruciating hallucinations plaguing Sebastián are socially mediated. His subjectivity, including his mental illness symptoms, is intricately tied to his interactions with family members within the home. Thus, while Sebastián's psychotic condition is not demonstrably caused by his family context, the content and unfurling of his psychotic symptoms are, to a considerable degree, socially, domestically, and politically produced.

Mental Illness on the Streets and in the Shelter. Homelessness, and housing instability in general, are associated with repeated traumatic exposures. As noted by sociologist and housing eviction expert Matthew Desmond,

> Residential stability begets a kind of psychological stability, which allows people to invest in their home and social relationships. It begets school stability, which increases the chances that children will excel and graduate. And it begets community stability, which encourages neighbors to form strong bonds and take care of their block (Desmond 2017, 296).

Homelessness and the ever-present threat of becoming homeless are "common, even normative" (Luhrmann and Marrow 2016, 211) states for those living with serious mental illness in the present-day United States. A multitude of "but fors" (Hopper 2003, 13) such as employment, government assistance, housing availability and condition, and highly variable, interpersonal relationships with family members, landlords, and neighbors determine housing status. For many seriously mentally ill individuals with broken kinship ties, a period of homelessness is nearly inevitable. If available and deemed safe, some seriously mentally ill individuals opt to stay in shelters, where they live at the whim of the set schedules of staff and unpredictable interactions with shelter mates.

As Hopper notes, "It is by no means clear how one is to distinguish bona fide 'symptoms' of mental illness from behavioral patterns that are the consequences of a homeless way of life, or indeed may be adaptions to it" (Hopper 1988, 158). In their study of mental illness and homelessness in Colombia, psychiatrists Esperanza Diaz, Alberto Fergusson, and John Strauss provide insights as to how conditions of homelessness and symptoms of mental illness interact to shape mental illness subjectivities. The authors describe three different stereotypical perceptions of public, psychotic mental illness and break down the ways in which the demands of a homeless life make public behavior nearly inseparable from psychotic symptomatology. For example, while a "guarded manner" (Diaz, Fergusson, and Strauss 2004, 233) might be clinically interpreted as a negative symptom of schizophrenia, Diaz et al. reason that the same behavior might be crucial to peacefully negotiating interpersonal disputes and successfully managing relationships in order to obtain food and shelter while living on the street. Wandering could be a sign of a hallucinatory state, but it could also be a way to leave uncomfortable situations, obtain disparate resources, or distract oneself from the side effects of drugs or medications. Delusions themselves could even be oriented to survival. The authors write,

> Delusions sometimes served to decrease the fear. Further symptoms in themselves, they nonetheless were attempts to solve problems as well. Examples of these included: delayed hunger, eagerness for activity, the magnetic cross of great power, the protector of the souls, and vicarious begging (234).

In his ethnographic work on New York City sidewalk vendors, sociologist Mitchell Duneier describes the "Fuck it!" (Duneier 1999, 60–61) mentality of homelessness, which he argues derives from "the representative moment of lethargic resignation, leading to a moment when a person gives up on culturally prescribed goals and means for living." This retreatism and associated bodily socialization enable a person to "sleep in his own or others' urine and feces on the street or among rats in the Bat Cave of the subway" and to engage in other acts that, from the outside, might be perceived as diagnostic of mental illness. These acts are often portrayed in the news media, where images of "bloated women with ulcerated legs and hollow-eyed men who shout obscenities in public spaces" (Hopper 1988, 162) warn the public of the homeless, dangerous mentally ill persons who occupy the streets.

Like the streets, shelters are unpredictable places filled with "stress, fear, and distractions" (Desjarlais 1994, 886). Foucault describes these types of arrangements as "communal houses for the sick," (Foucault 1994b, 40) or places that fleetingly serve as a family substitute by providing shelter and food to "sick persons who have no family." Per survey and ethnographic data, fear for personal safety is a primary reason that homeless individuals refuse to stay in shelters (Bourgois and Schonberg 2009, 27; Hopper 2003, 191). For those who do decide to stay, shelters provide relief from the elements at the cost of a "god-awful difficult" (Luhrmann 2010, 153) night of sleep and the requirement to abide by strict rules.

Danger, abandonment, and impermanence combine to create a potent, subjectivity-forming mix within the shelter where "everyday life orbits around efforts to keep shocks to a minimum and to hold oneself together" (Desjarlais 1994, 891). As Desjarlais again writes

> The themes common to many shelter lives are a political agency built out of tactical movements, an acutely tactile engagement with the world, a constant focus on daily concerns, a distanced style of communication, a poetics of pacing and talking centering on unconnected episodes, a makeshift economy of cigarettes and loans and conversations, and a ragtag collection of words, memories, images, and possessions (896).

This political agency is further exemplified by acts of preemptive aggression meant to diffuse dangerous scenarios and to ensure survival. Luhrmann illustrates this aggression in her ethnographic case study of Zaney, a woman living at a Chicago homeless shelter. Luhrmann writes that Zaney would "flare, raising her voice, throwing her shoulders back and her chest forward, acting fierce" (Luhrmann 2010, 155) whenever anything out of the ordinary happened or she felt threatened. What from the outside might look like florid psychosis was, for Zaney, a situation-specific protective behavior.

Conclusions. As dependent and seriously mentally ill persons move along the institutional circuit, they are influenced by an array of powerful disciplinary forces. These spatial moves occur through time and result in a complex amalgam of behavioral tendencies and mental illness symptoms. This personhood is not innate. Rather, it emerges "as patterns of historically situated ways of perceiving and engaging with the world" (Bourgois and Schonberg 2009, 18–19) and is induced by "the disciplinary and security processes of governmentality" inherent to each space.

Biehl writes that,

> In ancient Greece, every year two men – 'true scum and refuse' – were chosen to be cast out of the cities, as part of the festival of the Thargelia. Initially, these individuals were seen as the remedy for a city suffering from famine or pestilence; later, they became the means through which cities prevented mischief. These men were called *pharmakoi*, and, for them, there was no return to the city. Historians disagree over the ways in which they were chosen for this scapegoat role and whether they were actively killed or simply allowed to die (Biehl 2013, 257).

The institutional circuit is more than a network of supportive establishments for the modern-day *pharmakoi*. The circuit perpetuates mental illness symptomatology and produces *pharmakoi*. Academic and clinical analyses have generally not moved beyond a narrow, synchronic focus on the productive impact of singular institutions on mental illness. It is essential to expose the diachronic complexity of the circuit in order to understand the powerful historical influences that shape mentally ill persons' subjectivities across spaces and over time. A focus on, or at least an awareness of, this multi-spatial reality could help enormously in understanding the complicated cases that present daily to emergency rooms and hospitals.

A person's subjectivity, her sense of who she is and the actions that she takes as a result of this sense, develops in response to the institutions through which she passes. Agency surely exists, but the circuit is always a meaningful player. Dependent and seriously mentally ill persons encounter the world and experience their lives through the circuit. Through the circuit they come to understand their capacities and their mental illness symptoms - they come to know themselves. The productive impact of the institutional circuit on the diagnosis and treatment of mental illness should not be discounted or, worse yet, ignored.

Chapter 3

Ethnographic Interlude

Brian visited Las Vegas for 2 days, decided that he did not wish to work at his father's gaming store, and returned to Los Angeles to live with Meghan. Evelyn took a job with a new organization. Jennifer took over as Brian's case manager. I accompanied Jennifer to a brief introductory transition meeting with Brian. After the meeting, Meghan approached Jennifer and me and handed Jennifer a 12-page document that that she (Meghan) had compiled on Brian's psychiatric history. This document included information on Brian's psychiatric diagnoses, including schizophrenia and generalized anxiety disorder; his typical mental illness symptoms, including grandiose delusions that he is a god and persecutory delusions that President Donald Trump is attempting to assassinate him; his current and past psychiatric medications; and a list of his doctors and case managers.

Meghan also wrote about the circumstances preceding Brian's past psychiatric hospitalizations. These included a Xanax overdose, not having slept for multiple days, public urination and nudity, and suicidal statements. Brian had also been hospitalized several times following violent incidents. Meghan writes,

> He [Brian] would rage at me and get in my face, push me, poke me, slap my leg as he was yelling inches away from my face. I found kitchen knives lined up in the laundry room, one in the front yard and, after he was put on a [mental health] hold, a large one in his room. (I have pictures).

Prior to another hospitalization, Meghan writes that Brian,

> Was in the backyard talking to voices while construction workers were working next door. He asked them to be quiet because he was talking to very important people. When they did not stop making noise, he went into the house and grabbed a large butcher's knife, ran to the fence between the yards and threatened the workers.

Three months later, Meghan writes that Brian,

> Became agitated that my brother, William, was at the house. He [Brian] ran outside and verbally abused William, then proceeded to punch him [William] (when he [William] was crouching down doing some electrical work for me) in the back of his neck and shoulder. William defended himself, was able to tackle Brian and sit on him until the police came 8 minutes later. The police cuffed Brian and took him to the station.

Brian subsequently spent three nights in a psychiatric emergency room, received Haldol decanoate (a long-acting injectable antipsychotic medication), and discharged back to Meghan's home.

Six months later, Brian was hospitalized again. Meghan writes,

> Brian insisted I put money on his ATM card to purchase medical marijuana. When I refused, he started raging at me and called 911 (twice) to report me for 'Social Security fraud,' since I am his Representative Payee and control these funds. On the second call, Brian said, 'You're going to roll on me?' I assumed his erratic behavior prompted a car to be dispatched, so I called 911 a minute later to explain what was going on. The operator asked all the right questions and said she would send a unit.
>
> Officers arrived in about 20 minutes. I tried to explain the situation and give the officers my info sheet with Brian's psychiatric history including diagnosis's *(sic)*, behaviors, hospitalizations, medications and pertinent health provider information. They refused to take it. 'It's not procedure.' […].
>
> A 5150 call is a very emotional situation, preceded by an emotional day of psychotic behavior, verbal threats, and concern for my loved one. I was angry when the officer would not take my info sheet. When I do my NAMI [National Alliance on Mental Illness] CIT [Crisis Intervention Team] presentation for LAPD [Los Angeles Police Department] and Sheriff's Dept., the first thing I advise officers is that when they roll up on a 5150 where there is no imminent threat and a caregiver greets them at the street to explain what's going on, please say, 'Ma'am. I'm sorry you're going through this. We're here to help. What's going on?' This helps to put the caregiver at ease, helps with effective communication, and de-escalate (*sic*) the tension of the situation […]
>
> Brian stayed awake from (*sic*) over 40 hours between Friday morning and Saturday. He ate very little food – ½ taco on Friday, a bagel on Saturday, a 7-11 hotdog on Sunday. He would sit outside at morning and night, when temperature was 55-60 degrees, with no shirt or shoes. He is incapable of providing food,

> clothing, or shelter on his own. He's been off medication (Haldol) for approximately 2-3 weeks […].
>
> The officers said that because Brian had the wherewithal to buy beer and he doesn't look undernourished or tired and put a jacket on, he's fine. There was also a food wrapper they saw in the trash, so he [police officer] used this for an assumption that he [Brian] had eaten recently. That wrapper was from a few days ago […].
>
> Officer Smith scolded me for saying 'fuck' two, maybe three times. I was frustrated that they [police] were not listening to me and refusing to help. I feel they needed to see the bigger picture – Brian needs help. I felt dismissed and taunted. A 5150 call for your loved one is a very emotional situation.
>
> I told Officer Smith that I'm a NAMI presenter for LAPD and Sheriff's (*sic*) Dept. on CIT. He informed me that he had been trained in mental health six months ago and didn't see me there. Why did he just have to keep poking at me? The banter only made me more frustrated and angry. I think that was one of the times I said 'fuck.' I suppose he wanted me to know that he called the shots and nothing I could say would change that. And Brian suffers.

Before Jennifer and I depart, Meghan tells me that she plans to take go on the church trip to Nepal in 2 months. Meghan worries that Brian might decompensate while she is gone. Meghan's worst fear is that Brian will be sent to jail. Meghan points to the house next door and describes how her neighbor, a psychologist, is aware of Brian's mental illness history. Brian once threatened this neighbor with a knife. However, the neighbor was able to help Brian calm down and put the knife away. The neighbor did not call the police. Meghan worries that if Brian was to draw a knife on other neighbors or passerby, they might call the police and Brian might be sent to jail.

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

As is evident in Brian's case, 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, manages erratic and potentially violent public behavior in the context of street-based mental illness.

Policy scholar Michael Lipsky defines street-level bureaucrats as, "Public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work" (Lipsky 2010, 3). Lipsky further 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 or determine access to government rights and benefits." 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" (9). The decisions made by police officers in these highly personal, micro contexts are the focus of this chapter.

As noted by sociologist Linda Teplin, "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" (Teplin 1986, 1). 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, which consist of DMH social workers and police officers, and that respond to mental health crisis calls within given jurisdictions. 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 psychiatric 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 both connotes the side-by-side, cooperative partnerships that have formed between these entities, and the duplicative nature of police and social worker mental health assessments. With DMH social workers now at their side and/or independently writing hospitalization holds in the field, police officers do not have unilateral 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 of time. 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 psychiatric hospitalization hold so interesting is that it comprises a territory that it is neither clearly medical nor 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 seriously mentally ill individuals to the hospital for psychiatric assessment). As noted by anthropologist Paul Brodwin in his study of psychiatric social workers,

> A successful emergency detention requires careful planning and skillful negotiations with the police. [...] Emergency detention is a balky 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 (Brodwin 2013, 163–64).

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 seriously 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 even refusal, to assist in the hold process.

Such moments of debate occur when the police perceive a given DMH mental health hospitalization hold as a bad call. As noted by criminal justice scholar Peter Moskos in his study of urban policing, “bad calls” (Moskos 2008, 107) 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 do not have expertise in mental health assessment and treatment. Police officers mostly avoid mental health court hearings, where their opinions are 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, she makes a claim about police responsibility in managing the street. In these moments, the officer might utilize persuasive rhetorical arguments to protect her own job and the security of the police bureaucracy as a whole. This rhetoric is based in what Mary Douglas describes as Durkheimian sacralization, or the process of “placing certain aspects of social life beyond criticism or analysis” (Herzfeld 1992, 67). In this chapter, 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 involving psychiatric holds takes place within an important political economic context. While this context does not dictate police action per se, it provides police and social workers with few good options to turn to when deciding whether and where to send disruptive, seriously mentally ill individuals for psychiatric assessment. As again noted by Brodwin,

> 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 – where medical personnel and social workers practice their trades. 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 (Brodwin 2013, 1).

With deinstitutionalization, the total number of psychiatric inpatient beds 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, and nation-wide effort to develop alternative one-stop centers for mental health and basic needs (food, clothing, shelter, transportation) support for dependent and seriously mentally ill persons. Community mental health care and case management services do not provide for such persons to the same degree that state hospitals once more comprehensively and broadly did (B. Erickson 2021). Beginning in the 1960s,

> The rising cohort of young people with severe psychiatric 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. Many members of this group live in marginal, often dangerous surroundings, and they depend on an uncoordinated and underfunded collection of outpatient medical and social services. The severity of the 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. Separate agencies do not communicate well, and each has its own discrete mandate (housing, medications, employment training, addiction treatment, access to public subsidies, social rehabilitation, and criminal justice). They have little knowledge of each others' rules and operating procedures, and they enforce different expectations and eligibility criteria on clients. 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 the prevalence of serious mental illness in 2021 was estimated at 5.5% of U.S. adults, or 14.1 million people aged 18 or older, approximately 34.6% of these persons received no mental health treatment within the past year (National Institute of Mental Health n.d.). On a single night in 2022, approximately 582,500 people in the United States were homeless, including 65,111 in Los Angeles County (The U.S. Department of Housing and Urban Development n.d.). An estimated 25% of homeless individuals in Los Angeles County are seriously mentally ill (Caprara et al. n.d.).

Lumpen seriously mentally ill persons experience what anthropologists Nancy Scheper-Hughes and Philippe Bourgois describe as "structural violence" (Scheper-Hughes and Bourgois 2004, 1), or the asymmetric access to resources, security, and rights that dictates lives of poverty, hunger, and social exclusion. Structural violence also takes the form of 'Big Pharma' predatory accumulation, or pharmaceutical companies that operate principally to maximize profits at the expense of patients' health and economic well-being. The effectiveness of some medications in reducing psychiatric symptomatology bolsters companies' advertising efforts and contributes to professional perceptions of medications as a primary treatment for mental illness. This is at the expense of more time- and resource-intensive social interventions and psychotherapies (Sharfstein 2008).

The structural violence of mental health service fragmentation and pharmaceutical proliferation has coincided with what Scheper-Hughes and Bourgois further describe, after Basaglia, as “peacetime crimes” (Scheper-Hughes and Bourgois 2004, 19) committed by the state against seriously mentally ill persons. These crimes include practices such as police arrests, social worker holds, and jail and prison sentences, which destabilize seriously mentally ill persons’ lives at the expense of making “a certain kind of domestic peace possible” (20). Holds, arrests, and sentencings - whether medically warranted or not - confirm seriously mentally ill persons’ “worst fears and anxieties: that of losing themselves, their ownership of their bodies, to the random forces and institutionalized violence of the modern […] state” (Scheper-Hughes 1992, 20). Moreover, “stigmatizing legal records […] make housing and employment even harder to find,” (Brodwin 2013, 1) especially for individuals living in areas with rising property values, decreasing amounts of affordable housing, and high economic inequality. These macro-level, political economic perspectives of the mental health system are important to keep in mind when considering the micro, day-to-day interactions on the street between police, social workers, and the seriously mentally ill.

Violence and Serious Mental Illness. Media, popular culture, and even academic reports commonly associate violence with serious mental illness (Angermeyer, Cooper, and Link 1998; Pescosolido et al. 1999; Torrey et al. 2008; R. A. Van Dorn et al. 2005; R. Van Dorn, Volavka, and Johnson 2012). Anthropologist Janis Jenkins goes so far as to question whether “violence might be the critical master concept" (Janis H. Jenkins 2015, 227) for understanding the interplay between mental illness and society. Psychiatrist Franco Basaglia argued that the psychiatric profession, itself, coalesced around a societal need to triage violent, seriously mentally ill persons. Basaglia viewed care for the seriously mentally ill as based on a politically produced contradiction between providing for the sick and protecting the community, or "between medicine and law and order" (Davis 2012, 194).

Upon threatening or committing homicidal acts, seriously mentally ill persons are often effectively removed from society - and made obligatorily dependent - by way of commitment to hospitals, jails, and prisons. Whereas asylums were prevalent throughout the United States until the mid-20th century, the closing of many of these institutions resulted in a shift, in which many violent and seriously mentally ill individuals were then incarcerated in jails and prisons. Los Angeles County jail is currently the largest mental health institution in the country, and greater than 20% of jail inmates nationwide carry psychotic disorder diagnoses (Scull 2015, 378). Sociologist Nikolas Rose argues that the era of state hospital closures has coincided with a shift from institutional discipline to community-based governmentality in mental health care (Rose 1999). This governmentality, as exemplified by the mental health recovery movement, is based on an implicit agreement between the psychiatric patient and the psychiatrist, police officer, and/or social worker that the patient remain in the community as long as she is capable of self-governance in the way of psychiatric symptomatology and behavior (Braslow 2013). Should the patient become violent towards others, she is deemed de facto incapable of self-governance and can be hospitalized or incarcerated.

Public health researchers have thoroughly explored associations between mental illness and homicidal violence in the contexts of substance abuse, childhood traumas and family environments, prior violent acts committed, psychiatric medication adherence, and traits such as lack of illness insight and hostility (Haggård-Grann et al. 2006; Soyka et al. 2007; R. Van Dorn, Volavka, and Johnson 2012; Elbogen and Johnson 2009; Fazel, Gulati, et al. 2009; Fazel, Grann, et al. 2009; Swanson, Van Dorn, et al. 2008; Walsh et al. 2004; Swanson, Swartz, et al. 2008). Seriously mentally ill individuals are often described in academic and media reports as being more likely to be victims than perpetrators of violence (Jones and Shattell 2014). This well-intentioned, de-stigmatizing frame is true but misleading. The seriously mentally ill are actually more likely on average to be both perpetrators (up to 6 times) and victims (up to 140 times) of violence when compared to the general public (Fazel, Långström, et al. 2009; Maniglio 2009). The likelihood of perpetrating violence increases with decreasing age; young adults who experience first episode, or ongoing untreated, psychosis are up to 15.5 times more likely than same age, non-mentally ill individuals from the general population to commit homicidal violence (Nielssen and Large 2010). The combination of serious mental illness, poverty, childhood abuse and neglect, substance abuse, and exposure to community violence greatly increases the chance that a given individual will commit violence towards others (Miller and Hanson 2016, 235). Per results from a study of 1,136 inpatients discharged from acute psychiatric facilities, 31.3% of patients with mental illness and substance use diagnoses committed a violent act within one year of discharge compared to 17.9% of patients with only mental illness diagnoses (Steadman et al. 1998). Like violence in the general population, violence committed by seriously mentally ill persons is concentrated amongst a select few individuals (Collins 2009; Gardner et al. 1996; Skeem et al. 2016). The majority of seriously mentally ill individuals are not violent towards others (R. Van Dorn, Volavka, and Johnson 2012). In all, 85% of the violent acts committed by seriously mentally persons are against family and friends (Torrey et al. 2008, 149–50). The family reflects and responds to the violence foisted upon it by either preventing or provoking conflict (Swanson et al. 2006). Lumpen persons such as the dependent and seriously mentally ill often live in home environments that are “embroiled in intimate violence” (Bourgois 2009, 37). Families can be hotbeds for physical and verbal trauma, abandonment, and residential instability. These acts contribute to seriously mentally ill persons’ feelings of betrayal and mistrust (Janis H. Jenkins 2015, 152, 244, 258). Those who live in supportive family environments, where they feel listened to and appreciated by others, are significantly less likely to commit violence than those living in less supportive situations (Miller and Hanson 2016, 234–35)

Swanson et al. published the first large-scale study that showed a link between mental illness and violence. The authors utilized data from the NIMH’s Epidemiologic Catchment Area survey, a study performed in the 1980s in which 10,024 randomly selected, community-based mentally ill patients from Los Angeles, Raleigh-Durham, and Baltimore were interviewed about their psychiatric treatment and substance use histories, as well as any violent acts that they had committed during their lifetimes. The authors found a greater likelihood of violence among young men of low socioeconomic status. They also found that individuals with co-occurring mental illness and substance use were 2 times more likely to have committed violence than those with only mental illness diagnoses. Approximately one-third of those diagnosed with substance abuse and schizophrenia reported having committed violence against others. Overall, 90 percent of interviewees reported never having committed violence (Miller and Hanson 2016, 230–33; Swanson et al. 1990).

The MacArthur Violence Risk Assessment Study conducted from 1992 to 1995 was the next major investigation into the relationship between mental illness and violence. Researchers compiled a cohort of 951 patients ages 18-40 from university and state inpatient psychiatric units in Worcester, Pittsburgh, and Kansas City who carried diagnoses of depression, bipolar disorder, schizophrenia, and/or substance abuse. Researchers interviewed these patients about violence committed prior to hospital discharge and every 10 weeks after hospital discharge for 1 year. Researchers triangulated these patient accounts with collateral interviews from caretakers, as well as hospital and arrest records. Two hundred and sixty two patients (28%) committed violence within a year of discharge and accounted for a total of 608 violent acts. One percent of these acts were homicides, 3% involved rape, 26% involved a weapon, and 56% involved physical contact (hitting, biting, etc.) Twenty one individuals committed more than 5 violent acts, with 3 of these individuals accounting for 21, 25, and 41 violent acts each. The majority of these violent acts were committed against family members (51%) or friends and acquaintances (35%) in a home setting (Miller and Hanson 2016, 233–34; Torrey et al. 2008).

Public perceptions of violence committed by seriously mentally ill persons both drive research and underlie stigma towards the mentally ill (Angermeyer, Cooper, and Link 1998; Link et al. 1999; Pescosolido et al. 1999; R. A. Van Dorn et al. 2005). Over 60% of the general public views persons diagnosed with schizophrenia as inherently dangerous (Pescosolido et al. 1999; Torrey et al. 2008). This bias persists despite evidence from the MacArthur Study, which shows that there is little correlation between positive symptoms of schizophrenia, including delusions and hallucinations, and violence. Only 12% of participants in the MacArthur Study experienced delusions or hallucinations preceding their violent acts (Miller and Hanson 2016, 233–34; Torrey et al. 2008). Instead, anger, whether at psychotic symptoms or life stressors, is the strongest predictor that a person diagnosed with a mental illness will commit violence (Miller and Hanson 2016, 235; Skeem et al. 2016). Studies have specifically identified anger towards persecutory delusions and command hallucinations to be correlated with violence (Coid et al. 2013; Cornaggia et al. 2011; Green et al. 2009; Nolan et al. 2003; Ullrich, Keers, and Coid 2014).

Sociologist Randall Collins stresses the importance of micro studies to the theorization of violence. He argues that an understanding of when and how people connect or fail to connect emotionally, and in real-life interactions, is crucial to understanding when violence might occur and how it might be aborted. Collins defines confrontational tension and fear, or ct/f, as a feature common to all physically violent interactions. He argues that participants in a given interaction must overcome feelings of tension in order to enact violence upon others. This tension arises from human tendencies to align emotionally and to avoid conflict during intimate interactions. If an interaction escalates, tension can give rise to fear, which can induce aborted, incompetent, or inaccurate violence. Participants must thus find ways around tension and fear barriers in order to enact violence. Collins defines these pathways as attacking the weak, audience-oriented staged and controlled fair fights, confrontation-avoiding remote violence, confrontation-avoiding by deception, and confrontation-avoiding by absorption in technique. The violent elite, or individuals who commit the majority of violence in a given setting, are those who have developed a degree of emotional sensitivity and interactional skill necessary to effectively dominate confrontational space (Collins 1981; 2009)

Collins' ct/f model, however, explains little about violence committed by seriously mentally ill persons, who might overcome the ct/f barrier in spite of, rather than due to, emotional mastery and rational reasoning capacity (i.e. who may experience interpersonal dissonance in confrontational interactions that decrease their likelihood of committing abortive, incompetent violence (Fazel, Långström, et al. 2009; Maniglio 2009)). Violence circumvents relational complexity. It allows for a person who might not possess the "skilled interactional techniques" (Collins 2009, 10) required to navigate ct/f barriers to still dominate. As noted by anthropologist David Graeber, violence might be "the only form of human action by which it is possible to have relatively predictable effects on the actions of a person about whom you understand nothing" (Graeber 2012, 116).

Sociologist Randol Contreras also critiques Collins' micro model. Contreras acknowledges the model's usefulness in highlighting the emotional aspects of violent interactions, though calls for greater recognition of social and economic milieus to illustrate how violent interactions come to be in the first place. Contreras refers to violence as a "soup" (Contreras 2013, 168) that is filled with structural determinants, the ingredients that give violence "its flavor or aroma […] [that shape] its experience and texture." Contreras advocates for a move beyond micro perspectives in order to understand the deep structural roots that foment violence.

Discretionary Policing. In his book *Sidewalk,* Duneier examines the lives of vendors selling wares on the streets of New York City in the 1990s (Duneier 1999). In the classic sociological text *Street Corner Society*, William Foote Whyte describes the racketeering activities of men living in an Italian slum on the North End of Boston in the 1930s (Whyte 1955). 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 chapter.

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 seriously mentally ill individuals receive this clinical 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 seriously 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 what follows, 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 individuals to the hospital for assessment. I want to examine the ways in which police discretion is reflected in the rhetorical forms of concern, the persuasive arguments that the police make around liability, danger, and futility that attempt to informally, and at times extra-legally, establish boundaries for police responsibility in cases involving serious mental illness.

Ethnographic Cases. I present the following 4 cases as a set of 2 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 seriously mentally ill individuals, like Brian, receive formal psychiatric assessment at hospitals. As previously noted, these anxieties are expressed in a political economic context notable for safety net underfunding for mental health care and treatment. These anxieties also occur in the context of influential, socio-political movements of the 2010s and 2020s, including Black Lives Matter and, in particular, the highly publicized deaths of persons such as Eric Garner, George Floyd, and Jordan Neely, which have brought increased public scrutiny to street-based police and vigilante actions. While not the outright focus of this chapter, it is crucial to keep this context 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.

The cases all take place in the Los Angeles metro area, where Brian also lives. 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 seriously mentally ill person 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 seriously 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 seriously mentally ill individual is transported to the hospital. In Cases 1 and 3, police decision not to act leads to the seriously mentally ill individual being left in their community or home. The 4 cases are drawn from 15 ethnographic observations of mental health hold interactions between police and seriously mentally ill individuals. Of these 15 interactions, the police chose not to assist, physically or otherwise, in ensuring that the seriously 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 seriously 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 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" (Fassin 2016, 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 seriously 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 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 Black 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 seriously 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 losing 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 Black 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, speaks to herself, and holds 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 says that he 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 car. The ambulance that Mark requested earlier arrives and also 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 Iris 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,” Johnson says. 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. One hundred percent of the time we won't chase.

Johnson thinks for a 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." Johnson believes that 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 [Iris]," 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. Police view social workers as civilians trying to help the mentally ill. 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. 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 with transportation 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 5 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 for transport. 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. Kleinman is in charge. Reardon is a deputy in training. Jessica informs the officers about Julia's case. Kleinman asks whether Julia has a history of violence. 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 3 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 DMH, a government organization. Kleinman returns to his squad car, calls his sergeant, and walks back to our group. He relays the sergeant’s message 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. He comments that he agrees 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 the 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 also 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 Julia off at the urgent care, present the paperwork, and leave. The physician at the urgent care will then assess, and decide whether to hospitalize, Julia.

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 says that she is worried about parole issues. 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 Black 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 the team can provide Derek with any food or other goods. 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, this 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, 3 more officers arrive. The crowd begins to draw extended stares from motorists and pedestrian passerby. For the next 20 minutes, the officers ask about details of the case. Ramos summarizes what she knows so far and shares Derek's height and weight. The officers are interested in these measurables in the event that physical force with Derek is needed.

Lieutenant Adams and a 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 individuals in order to avoid the use of police force in psychiatric hold scenarios. Adams gregariously shakes Paul's hand. Paul passes the hold and court paperwork to 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 5 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 and calls Paul a “snake” who tricked him [Derek] into treatment. Paul responds that he [Paul] is only following court orders. Derek continues to explain that God is the judge, not Paul nor 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 end with a second case in which a seriously mentally ill individual has locked himself in a private residence. The officers involved in 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 individual, the officers in Case 4 do not engage an individual who has a violence 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 to self or others, nor gravely disabled, and discharged 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, yells racial obscenities at strangers, and shoots 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. Paul 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 for 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 Zach 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, Black 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, 4 more squad cars pull up. Officer Ramos steps out of 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 nor dangerous and allowed Zach 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. A variety of pill bottles fly out of the open 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 10 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 and states, “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. He continues,

> 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. Still intent on making his case, Paul continues to engage Bradley. For the next half hour, Bradley, O’Hare, Paul, Mark, and Patricia debate. 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 executing psychiatric 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 remains unwilling to press criminal charges against Zach or 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 [Zach] 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 Black), 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 police or patient 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 and says, “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 [Zach] 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, which has been signed and stamped by Judge Lee. Bradley skims the sheets, 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.”

Paul asks frustratingly, “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 assess this situation. 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 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 drives 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 4p.m. 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, Mark 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. He continues, "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 to physically engage seriously mentally ill individuals in order to ensure transportation to the hospital for psychiatric assessment. I also discuss the broader bureaucratic anxieties that correspond to this rhetoric.

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, who 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, or 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 could have on his own physical safety (running through traffic) and personal security, particularly related to his job and family, should the altercation be witnessed by the public.

Sheriff Johnson's inaction reflects his place within the police bureaucracy. As noted by policy scholar Gerald Britain, "The most basic goal of any bureaucrat or bureaucracy is not rational efficiency, but individual and organization survival" (Britain 1981, 11; Herzfeld 1992, 5) This is seconded by Lipsky, who notes that, "At the very least, workers have an interest in minimizing the danger and discomforts of the job" (Lipsky 2010, 18). While physically detaining Iris, who repeatedly runs through traffic and puts herself and drivers in danger, might seem to be a rational decision, Johnson instead opts 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 seriously mentally ill individuals in scenarios that could be witnessed by the public, broadcast via the news and social media, and portray 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 police officers' and Zach's safety should police enter the home, but he also fears for police 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 anthropologist Michael Herzfeld, "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" (Herzfeld 1992, 142) 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 the extent of police responsibilities in working with seriously mentally ill individuals.

Futility. In Case 1, beyond liability and danger, Sheriff Johnson gives a myriad of excuses related to futility for why he does not want to, and ultimately will not, use physical force to place Iris on a hold. 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 seriously 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 serious 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 who 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, Bradley 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 seriously mentally ill individuals. Instead, he is a 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 in this system-blaming orientation. 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" (80). This 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." 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 serious mental illness.

Conclusions – 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 serious mental illness. These individual concerns and bureaucratic anxieties serve to maintain police responsibilities within a carceral realm in the context of mental illness policing.

In review, all police officers in the four preceding ethnographic 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" (Lipsky 2010, 13) and the legal standard is not always upheld.

What is perceived from the outside, both by social workers and by family members like Meghan, as discretionary decision-making by police officers, is really a larger bureaucratic effort to extra-legally define the boundaries of responsibility for seriously mentally ill persons like Brian. In other words, what appear as arbitrary decisions by individual officers are really symptoms of a larger police institution asked to respond in ways outside of its carceral expertise. 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 seriously mentally ill person should be placed on a hold; officers act only to deter violence and not to physically assist in transporting seriously mentally ill individuals to the hospital for psychiatric assessments.

However, for an emergency mental health system to adequately function, there cannot be bad calls. There cannot be individuals who meet criteria for psychiatric assessment, yet who 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 serious 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, 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 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 is safely sent to the hospital for psychiatric assessment. Ideally, none of these cases would involve police carceral expertise. The seriously mentally ill individuals involved would not be arrested and 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 – as an act within their bureaucratic boundaries.

While the 4 cases included in this analysis are specific to psychiatric hold scenarios, the need to eliminate 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 such a world, individual police officers would not need to argue that danger, liability, and futility exculpate them from ensuring that acutely mentally ill individuals like Brian 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 like Meghan, physicians, and others involved in caring for and treating seriously mentally ill persons. Case 3 provides an example for how this might work.

While not explicitly explored in this chapter, social factors including race, class, and gender dynamics influence police interactions with civilians and must also be accounted for in any discussion of police extra-carceral bureaucratic responsibilities in managing street-based serious mental illness. In the wake of the Black Lives Matter movement, and the visceral deaths of persons like Eric Garner, George Floyd, and Jordan Neely, these social factors are at the forefront of officers' and civilians' minds in street-based interactions. As shown in Case 1, Sheriff Johnson chose not to physically engage or chase Iris, a Black woman who wore tattered clothes and repeatedly ran 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 did not receive a psychiatric assessment due, in part, to Johnson's logic. Society-wide conversations about police use of force, and the race, class, and gender dynamics involved in police-civilian interactions, are thus highly relevant issues to the policing of street-based serious mental illness.

The public mental health care system, of which street-based serious 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. The label of interloper, or custodial, status must be removed from street-based serious 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 right - professionals who work in concert with a broader system of clinicians and family members to pressure political institutions to provide the basic needs (food, clothing, housing, transportation) and treatment (therapy, medications) that keep dependent and seriously mentally ill individuals off the streets and in supportive treatment and care environments.

Chapter 4

Ethnographic Interlude

Meghan ultimately decided to go on the month-long church trip to Nepal. Upon her return to Los Angeles, I visited her at her home. As I approached her house, she activated an electronic gate, which swung open so that I could walk up the driveway. She explained that she had the gate installed to prevent her new dog from running away. I asked her about the Nepal trip. She said that she had a great time traveling and commented on how it was nice to get a break from caring for Brian. As she could not think of other realistic options, while in Nepal, she left Brian in Simone's care. Brian decided to travel to Florida to spend time with his father Jake, "went off his meds, took a while to decompensate," returned back to Los Angeles, and is now acutely ill again. Meghan describes how Brian is barely eating, is "going between god and the devil," and is telling Meghan that she has "lizard eyes."

Meghan begins to brainstorm alternative living arrangements for Brian. She does not wish for Brian to be homeless and to experience the inevitable traumas of the street. She is wary about placing Brian in a board and care for similar reasons. She laments that she will just try to do her best to continue caring for Brian at her home. Meghan and I walk down the driveway together, conclude our conversation, and say goodbyes. Meghan closes the electronic gate behind us. I walk across the street, get into my car and, as I punch driving directions into Google maps, notice Meghan drive away. I then see Brian open the driveway gate, walk to the end of the driveway, and stand facing the street. He is shirtless and barefoot. Meghan's dog ambles past Brian, stops to sniff, and then sprints across the street. Brian slowly walks back towards the garage and returns to the end of the driveway with a leash. He tries to get the dog to return by calling its name, but the dog runs down the street and disappears. Brian again turns slowly and walks back inside Meghan’s home.

Two days later, Brian was again hospitalized. TV film crew members, who were shooting a scene across the street from Meghan’s home, witnessed Brian threatening Meghan in Meghan’s front yard. Per Meghan, the crew members “came running over to help” and Brian “stood out front shirtless and shoeless, yelling [at] and taunting the film crew.” Simone called 911, the police arrived, and an ambulance transported Brian to the hospital. Doctors gave Brian Haldol decanoate along with oral Haldol pills. Five days later, doctors discharged Brian back to Meghan’s home. Brian stopped taking the oral Haldol and declined to meet with his case manager, Jennifer. He began to urinate outside and in public view of the next door neighbors. When Meghan confronted Brian about this behavior, Brian replied, “I’m a guy, so I can do this.” In reference to the neighbors, he stated, “The little girls are dead.” Though no harm had come to the next door children, Meghan worried that Brian might be thinking about hurting them. Meghan exasperatingly states, “I have no fricken’ life. All I do is take care of Brian. It is hard to stop when your son says that the girls next door are dead.”

Three months later, Brian assaulted a police officer and was sent to jail. Meghan had called 911 after Brian became verbally and physically aggressive towards her. Meghan recalls how, when the police arrived, Brian “looks out a window, sees the cops, and takes off running down the alley behind the house. I [Meghan] received a call from the police later that day saying, ‘I [police officer] found Brian. He took a swing at me and he is going to jail.’” Brian spent 2 days in an admission facility and then 3 days in Twin Towers Correctional Facility, a jail on the outskirts of downtown Los Angeles. Meghan posted $10,000 bail with credit card advances and money from her Individual Retirement Account (IRA). Brian subsequently attended mental health court. According to the terms of his year-long probation, Brian must be enrolled in psychiatric services and AOT. In order to alleviate financial stress, Meghan plans to sell her home. She wistfully states, “Maybe he [Brian] needs to be homeless for a week or two [in order to appreciate what he has].”

Homelessness, Psychosis, and a Lethal Neglect of Dependency in Los Angeles County

In the span of 60 years, the foundation of American mental health policy and infrastructure has shifted from one based on the overt absolute dependence of state mental hospitals to an implied independence stance of recovery. In between, a stage of relative dependence was largely passed over. Even for the most structurally overwhelmed persons, the current public mental health system promotes an ideal of independence. Persons who cannot reasonably engage in this push for independence, including many homeless and seriously mentally ill individuals, can be left abandoned, destitute, and traumatized.

Psychiatrist H. Richard Lamb asserted in 1984 in the journal now known as *Psychiatric Services* that,

> We have learned that we must accept patients’ dependency when dealing with the chronically mentally ill. And we must accept the total extent of patients’ dependency needs, not simply the extent to which *we* wish to gratify these needs. We have learned, or should have learned, to abandon our unrealistic expectations and redefine our notions of what constitutes success with these patients. Sometimes it is returning them to the mainstream of life; sometimes it is raising their level of functioning just a little so they can work in a sheltered workshop. But oftentimes success is simply engaging patients, stabilizing their living situations, and helping them lead more satisfying, more dignified, and less oppressive lives. The reluctance of mental health professionals and society to fully accept the dependency of this vulnerable group, inadequate case management systems, the preference of many mental health professionals to work with more ‘healthy’ and ‘savory’ patients, and an ideology that ‘coercive’ measures should be used only in cases of ‘extreme danger’ leave the homeless mentally ill in extreme jeopardy. If deinstitutionalization has taught us anything, it is that flexibility is all important. We must look objectively at the clinical and

> survival needs of the patients and meet those needs without being hindered by rigid ideology or a distaste for dependency (Lamb 1984, 906–7).

By the end of the 1980s, however, an alternative movement to what Lamb proposed had coalesced. Broadly known as recovery, this movement focused on principles of patient autonomy, community integration, and hope. By the turn of the 21st century, most state mental health departments, as well as the federal government, advanced policies based on recovery principles (Braslow 2013; Myers 2015). Such a pivot can be seen in California's 2004 passing of the Mental Health Services Act, which funded a recovery-based transformation of the state's mental health system (Ashwood et al. 2018). As argued by psychiatrist and historian Joel Braslow, in practice, recovery discourse could blur with neoliberal welfare reform rhetoric, which aimed to minimize patients' dependence on publicly funded social and health aid systems (Braslow 2013). A result of this blurring could be a "depersonification (Rinsley 1982), whereby the patient is expected to behave as a mature and polite adult despite severe psychopathology" (Gabbard 2014, 165). This despite employment data, which show that, "At any given time, as few as 10% of people with schizophrenia are employed on a competitive basis (Marwaha et al. 2007), with some studies suggesting that as many as half of all people with schizophrenia never work at a competitive job for a sustained period (McGurk et al. 2003)" (Fundora et al. 2021, 96). Psychiatrist Glen Gabbard further describes depersonification as having "often been the life story of the severely disturbed patient in terms of interactions with family members" (Gabbard 2014, 165–66). The recovery movement, arguably, extended this story outside of the family environment and to the jails, shelters, and streets where many dependent and seriously mentally ill persons lived.

Pediatrician and psychoanalyst Donald Winnicott theorized that an appropriate balance of dependence and independence is fundamental to all healthy human relationships (Mitchell and

Black 2016, 124–34). Winnicott delineated three specific forms of dependency: 1) absolute dependence; 2) relative dependence, or an individual's awareness of and ability to communicate dependent care needs; and 3) towards independence, or an individual's insight into personal abilities and limitations, as well as her situational capacity to live independently (Winnicott 1960). Winnicott believed that "preoedipal conflicts," (Auchincloss and Samberg 2012, 194) or problems with "dependency, attachment, and control," could be "prominent in the psychological life of individuals who have experienced early maternal deprivation or loss, or other kinds of physical and/or emotional trauma." He professed that a "good-enough environment [was] necessary for the consolidation of a healthy sense of self" (Mitchell and Black 2016, 129). Ideally, such an environment would be both protective and permissive. It would provide the "optimal amount of comfort and frustration" (Auchincloss and Samberg 2012, 283) needed for personal growth. Without such a balance, Winnicott hypothesized that development towards functional and emotional independence might stall (Mitchell and Black 2016, 129).

While Winnicott focused on parent-child dyads, scholars have extended these insights to other dependent relationships, such as that between society and dependent adults (Luepnitz 2015). This scholarship has shown that, in places like Los Angeles County, there is little semblance of a guaranteed, good-enough holding environment for homeless, seriously mentally ill, and dependent persons. Instead, treatment and care for such individuals is based on what anthropologist Kim Hopper describes as "but fors." These factors - which "make the difference between the margins and the street" (Hopper 2003, 13) - include individuals' variable abilities to maintain reciprocal relationships with friends and family and to obtain adequate employment, government assistance, and housing.

Ethnographic Cases.

Stewart: Stewart is an elderly, Black man who has a psychiatric diagnosis of schizophrenia and a known medical diagnosis of diabetes. For 20 years, Stewart has slept on various beaches throughout Los Angeles County. For unclear reasons, Stewart is largely immobile. He defecates in his sleeping bag and throws the feces on the beach nearby. On at least 1 documented past occasion, social workers brought Stewart to an emergency room for a medical evaluation for grave disability, or inability to care for himself to the point of being at risk for death or serious injury. Stewart was deemed to not to be gravely disabled nor to have an acute medical condition that would necessitate an inpatient medical admission. He was discharged from the emergency room to the street. Over the course of a year and a half, AOT outreach workers made numerous attempts to engage Stewart, though Stewart consistently declined psychiatric services.

I include the following fieldnote excerpt from one of these outreach trips, on which I accompanied AOT social worker Darian:

As Darian and I walk down the beach, Darian loudly shouts, "Stewart! Hey! Stewart!" Stewart sits up in a sleeping bag. He appears disoriented. He shades his eyes from the sun and quickly looks from side to side. Darian states that he is here with AOT to offer mental health services.

Stewart replies, "No! Go away! I will call the police!"

Darian then asks whether Stewart has sufficient food and water. Stewart shifts in his sleeping bag and exposes his naked and sand-plastered lower body. He rummages through a nearby plastic bag, pulls out a full bottle of iced tea, and raises it in Darian's direction.

Darian and I say goodbye and depart. Darian then receives an email from his AOT supervisor, which reads, "As ambivalent as I am about it, I will re-refer Stewart to SB-82, who might help. My feeling is that Stewart's refusal to even talk to AOT will continue." Darian explains that SB-82 refers to an outreach team that will intermittently check on homeless persons like Stewart.

On our way to visit another AOT client, Darian then shares that he might drop Stewart from the AOT caseload. I ask why AOT would stop attempting to move forward with treatment for Stewart, when Stewart is locatable and appears fairly disabled. Privately and to myself, I also wonder whether Stewart would now meet criteria for grave disability given his advanced age, untreated diabetes, and difficulty walking. Darian explains that Stewart,

> Doesn't understand what a petition does. No matter who offers services, Stewart refuses. So we are just going to send SB-82 out once in a while to check on him. Between you and me, they will go out once and he will be dead. AOT can't conserve Stewart because Stewart doesn't have enough hospitalizations to justify a conservatorship. The California government changed the criteria for state hospital admission, so Stewart would need to be found criminally insane to go there. Again, Stewart wouldn't meet criteria. Stewart is dying, but it is not against the law to sit on the beach and die. People fall through the cracks when they do not have enough violations to get conserved and when they are not willing to go along with any voluntary outpatient mental health treatment.

In the end, Darian does discharge Stewart from AOT. Darian hands Stewart's case off to Nick, a case manager at an outpatient mental health clinic. I later interview Nick, who informs me that his clinic is also "going to let [Stewart] go." Despite numerous offers from the clinic, Stewart declined all services. Nick explains to me that, "You can't take someone away from the place they are in. Stewart doesn't want any help. Throwing him in the hospital and making him take services he doesn't want isn't really something we want to do."

Kelly: Kelly is a young adult, Latina woman who was diagnosed with schizophrenia in the setting of a pregnancy, and who then subsequently assaulted her mother. Kelly's mother kicked Kelly out of their shared home. Kelly then also lost custody of her now 6 year old child.

I include the following fieldnote excerpt from an outreach trip with AOT workers Virginia and Peg:

Virginia, Peg, and I approach Kelly, who says hello and busies herself brushing dust off of and folding a set of clothes. The scene is shocking. Kelly's clothes sit on a patch of dirt on the side of a one-way alley. The alley is narrow – just wide enough for a single car to pass through. A cot-size bed sits wedged next to a garage door. The foot of the bed is inches from the alley's driving surface. The bed is strewn with debris. The whole area is swarming with black flies.

As Kelly works, she speaks rapidly to herself. She finishes sorting the clothes, places them in a large backpack, motions for us to follow, and says that she will bring us to see her mother. We follow her out of the alley to a small, non-descript home. Kelly bangs on the front door and yells, "Mommy! Mommy!" After a few unsuccessful repetitions, Kelly tells us that she thinks her mother might be at the laundromat. She again motions for us to follow. We walk a few blocks to a strip mall laundromat and go inside. There are only a few people inside the shop and Kelly does not appear to recognize anyone.

Virginia asks if Kelly is interested in mental health services. Kelly declines, though says that she would appreciate housing. Virginia then asks whether Kelly would like any food. Kelly requests a Big Mac and a drink from McDonald's. Virginia, Peg, and I leave to purchase the food. Kelly sits on the sidewalk outside of the laundromat.

When we return with the food, Kelly is still seated on the curb, though there is now a man standing over her. He smiles at us as we pull up in our car. However, when Virginia gets out of the car and begins to talk to Kelly, the man turns and enters the laundromat. Virginia hands Kelly a burger and a drink and informs Kelly that we will return in a few days for another checkup. Virginia, Peg, and I then drive back to DMH headquarters. During the drive, Virginia asks whether either of us noticed the knife that that the man was carrying. Peg notes that the AOT caseworkers assume that a group of men in the area routinely pay Kelly with drugs, especially methamphetamine, in exchange for sex. Peg recalls how one of the homeowners along Kelly's alley maintains a video camera to monitor vehicles parked in his driveway. He told AOT caseworkers that he has seen film of men beating Kelly in the alley. Virginia and Peg have never seen Kelly being actively beaten, though do recall Kelly's many unexplained facial bruises.

Discussion. Stewart and Kelly experience such extreme degrees of "social abandonment" (Biehl 2013, 2) that it is difficult to imagine the "amount of good behavior or self-control" (Desmond 2017, 219) that could relieve them from their predicaments. Apart from the occasional beachgoer or lifeguard, Stewart exists largely apart from human contact. He suffers from untreated diabetes and undifferentiated, debilitating mobility issues. He uses a sleeping bag as a shield from the elements, as his bedding, and as his restroom. Kelly constructs a most intimate space - a bedroom - in a busy alleyway. There, she is physically and sexually assaulted. She sleeps blocks away from the shelter of her mother's home, where she once lived.

Philosopher Judith Butler describes life circumstances like those of Stewart and Kelly in terms of "precarity" (Janis H. Jenkins 2015, 13). Butler writes,

> 'Precarity' designates that politically induced condition in which certain populations suffer from failing social and economic networks of support and become differentially exposed to injury, violence, and death. Such populations are at heightened risk of disease, poverty, starvation, displacement, and of exposure to violence without protection (Butler 2009, ii).

For Butler, precarious lives are those that "do not qualify as recognizable, readable, or grievable" (xi-xiii) by society at large. This indifference – elsewhere described as "compassion fatigue" (Hopper 2003, 180) – "provides a moral alibi for [societal] inaction" (Herzfeld 1992, 33) around the complex and longstanding condition of homeless serious mental illness, a public "spectacle" (Hopper 2003, 193) that "now passes for 'normalcy' in American cities."

Stewart and Kelly have reached precarious inflection points beyond which death from environmental exposure and interpersonal violence seem imminently possible. They live at these tipping points because of "structural violence" (Scheper-Hughes and Bourgois 2004, 1). In simplest terms, the society in which they live does not dependably meet their basic needs. In reference to such overt neglect, anthropologist Lorna Rhodes notes that persons like Stewart and Kelly "'fall between the cracks' of the [recovery-era treatment and care] system in ways that parallel their abandonment to the 'warehouses' of the old [asylum] system" (Rhodes 1995, 82). I theorize that this neglect, to the point of serious injury or death, is probable, if not inevitable, in a capitalist society that lacks adequate safeguards for dependent persons.

Writing in the wake of the Industrial Revolution, sociologist Émile Durkheim sought to elucidate the forces that bind society together. Whereas religion once provided the solidarity necessary for collaboration, Durkheim concluded that division of labor now served as the primary driver of social cohesion. Durkheim discussed how each individual has a duty to devote herself to a worthy task, and therefore to contribute to social solidarity (Durkheim 1964). The notion that a euthanasia of dependent persons – or those who do not fulfill Durkheim's division of labor roles - might be inherent to individualistic, capitalist societies harkens to early 20th century German legal studies. Psychiatrist Alfred Hoche and scholar Karl Binding introduced such thinking - which would later be used by Nazi Germany to justify killings of mentally ill and disabled persons - with their 1920 book *Die Freigabe der Vernichtung lebensunwerten Lebens.* Binding and Hoche write,

> Are there human lives that have so lost the quality of legal good that their very existence no longer has any value, either for the persons leading such a life or for

> society […] Whoever poses this question seriously must, with bitterness, notice the irresponsibility with which we usually treat the lives that are most full of value, as well as with what – often completely useless – care, patience, and energy we attempt, on the other hand, to keep in existence lives that are no longer worthy of being lived, to the point at which nature herself, often with cruel belatedness, takes away any possibility of their continuation (Binding and Hoche 1920, 27–29; Agamben 1998, 138).

Psychiatrist and philosopher Victor Frankl - himself a Holocaust survivor – lamented that euthanasia is a logical, if rarely realized, possibility in societies that are based on individual "achievement orientation" (Frankl 2006, 152–53). Frankl writes, "'Mercy' killing of all those who have lost their social usefulness, be it because of old age, incurable illness, mental deterioration, or whatever handicap they may suffer" could be justified in perverse societies that do not differentiate "between being valuable in the sense of dignity and being valuable in the sense of usefulness."

There is no direct, government-sanctioned euthanasia of dependent seriously mentally ill persons in Los Angeles County. Yet, as is evident in the precarious living conditions of Stewart and Kelly, Angeleno society undoubtedly lethally neglects those who do not live up to economic independence standards. Such neglect echoes Friedrich Engels' notion of social murder. In his 1845 text *The Condition of the Working Class in England* (Engels 2009),

> Engels made the case for accusing – and convicting - the English bourgeoise [the capitalist class who owns most of society's wealth and the means of production] and ruling authorities of social murder for causing the premature death of workers in Victorian-era England […].There are four key components to Engels' concept of social murder. The first is individuals – usually workers – die prematurely as a result of their living and working conditions. The second is that these living and working conditions are a result of workers' exploitation under capitalism. The third is there is a class within society – the bourgeoisie – that benefits from this exploitation. The fourth is since the bourgeoisie and ruling authorities are aware of these processes yet do nothing to change them, they are guilty of social murder (Medvedyuk, Govender, and Raphael 2021, 1–2)

Unlike social murder, however, I use the term lethal neglect here to refer to a morbid, societal disregard of *non-working, dependent* persons.

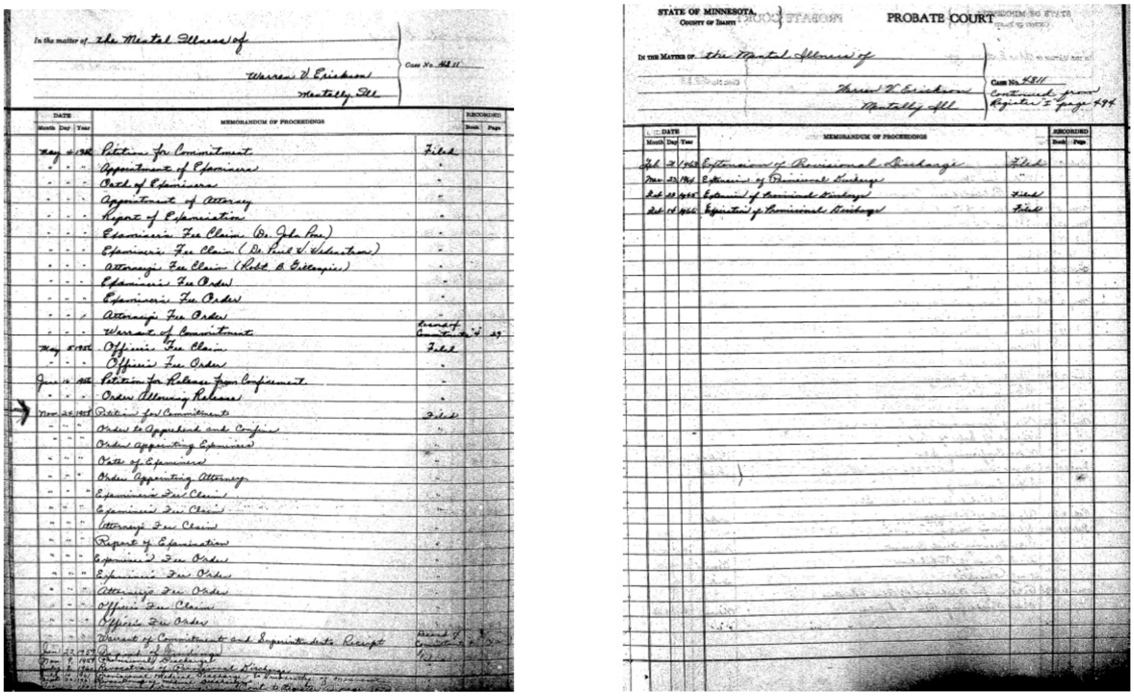
Conclusions. Should Megan kick Brian out of her home, and given Brian's lack of financial prospects, he is likely to experience the many brutalities inherent to street homelessness, including environmental exposure and repeated violent assault (Torrey 2014, 128). In this chapter, I presented two illustrative ethnographic cases, both drawn from psychiatric homeless outreach work in Brian's native Los Angeles County, that illustrate such indigence. I also proposed a sustaining political economic mechanism – lethal neglect – for this societal crisis of dependent, homeless serious mental illness.

Good-enough holding environments - or those that account for the real life, relative dependence of persons like Stewart, Kelly, and Brian – do not come cheap (Sisti, Segal, and Emanuel 2015, 244). One such place, the Worcester Recovery Center and Hospital in Massachusetts – a long-stay, not exclusively forensic, facility with 320 private rooms – "cost $300 million to complete [in 2012], making it one of the most expensive non-road construction projects in the state's history. […] In 2015, Massachusetts spent $55,000 per prison inmate, with some additional costs for those with serious mental health issues. Meanwhile the Worcester Recovery Center, with an annual budget of $60 million, spent close to four times that sum per patient" (Oshinsky 2023).

To correct the misaligned dependency relationship between American society and homeless seriously mentally ill persons, we must argue on primarily ethical, not economic, grounds. To create and sustain good-enough holding environments for these persons is, after all, to embrace the highest "ethical imperative" (Myers 2015, 154) – to value human life. Such a stance necessitates a pivot away from a “U.S. achievement ideology that urges high profit and self-interest – that values money and consumption over non-economic or non-material goals” (Contreras 2013, 70). Historian Julie Livingston defines such an argument in terms of a moral order, or “a shared set of values held by society that guides its members in expected conduct and provides a way to judge or interpret the actions of others” (Livingston 2005, 20). Physician-anthropologist Claire Wendland further clarifies that a moral order “is *moral* because it is about assigning value, about deciding what is good or bad, and it is an *order* because it is an organizing schema with which we understand our own and others’ actions” (Wendland 2010, 15). To counteract lethal neglect, we must “eradicate contempt for those who are disfavored by the ethic of effortful competition” (Appiah 2018, 183–84), and soberly recognize and determinedly fulfill their dependent needs.

Conclusion

I begin the end with a personal epilogue, of sorts. My interest in questions of psychosis and dependency derives, in part, from my love for, and childhood attempts to understand, my grandfather. Grandpa Warren, who died in 2003, was diagnosed with a psychotic illness soon after World War II, when he returned from the Army Air Corps to his rural Minnesota hometown and began to exhibit religious delusions and disorganized behaviors. He was subsequently hospitalized for a decade at several state institutions (Figure A), underwent ECT, received antipsychotic treatment, and was enrolled in university research studies. Despite these trials, he had 7 children, including my father, and worked in auxiliary roles at the local bank run by his family.



In the matter of the Mental Illness of
Warren V. Erickson
Mentally Ill
Case No. 4811

DATE Month	Day	Year	MEMORANDUM OF PROCEEDINGS		RECORDED Book	Page
May	4	1952	Petition for Commitment	Filed		
"	"	"	Appointment of Examiners	"		
"	"	"	Oath of Examiners	"		
"	"	"	Appointment of Attorney	"		
"	"	"	Report of Examination	"		
"	"	"	Examiners Fee Claim (Dr. John Rose)	"		
"	"	"	Examiners Fee Claim (Dr. Paul S. Sebastian)	"		
"	"	"	Attorneys Fee Claim (Robt. B. Gillespie)	"		
"	"	"	Examiners Fee Order	"		
"	"	"	Examiners Fee Order	"		
"	"	"	Attorneys Fee Order	"		
"	"	"	Warrant of Commitment	Record of Commitments	4	27
May	5	1952	Officers Fee Claim	Filed		
"	"	"	Officers Fee Order	"		
June	16	1952	Petition for Release from Confinement	"		
"	"	"	Order Allowing Release	"		
→ Nov	24	1958	Petition for Commitment	Filed		
"	"	"	Order to Apprehend and Confine	"		
"	"	"	Order appointing Examiners	"		
"	"	"	Oath of Examiners	"		
"	"	"	Order Appointing Attorney	"		
"	"	"	Examiners Fee Claim	"		
"	"	"	Examiners Fee Claim	"		
"	"	"	Attorneys Fee Claim	"		
"	"	"	Report of Examination	"		
"	"	"	Examiners Fee Order	"		
"	"	"	Examiners Fee Order	"		
"	"	"	Attorneys Fee Order	"		
"	"	"	Officers Fee Claim	"		
"	"	"	Officers Fee Order	"		
"	"	"	Warrant of Commitment and Superintendents Receipt	Record of Commitments	[illegible]	[illegible]
Jan	22	1959	Report of Findings			
Nov	9	1959	Provisionally Discharged			
July	8	1960	Revocation of Provisional Discharge			
[illegible]	14	1961	Provisional Medical Discharge to University of Minnesota			
[illegible]	20	1961	[illegible]			
[illegible]	[illegible]	1962	[illegible] Cont. to Register [illegible] page [illegible]			

STATE OF MINNESOTA,
County of Isanti
PROBATE COURT

In the Matter of the Mental Illness of
Warren V. Erickson
Mentally Ill
Case No. 4811
Continued from Register "I" page 494

DATE Month	Day	Year	MEMORANDUM OF PROCEEDINGS		RECORDED Book	Page
Feb	7	1963	Extension of Provisional Discharge	Filed		
Mar	23	1964	Extension of Provisional Discharge	"		
Feb	28	1965	Extension of Provisional Discharge	Filed		
Feb	14	1966	Expiration of Provisional Discharge	Filed		

Figure A: Record of one of my grandfather's state hospital admissions.

Grandpa Warren was idiosyncratic, miserly, and, at times, unpredictably and irrationally critical towards his wife and children. My dad and his siblings were, de facto, raised by my grandmother, Leone, in a quasi-family welfare system. Leone worked and cared for her children. Warren, through his siblings and parents, was ensured paid work at the bank when he was not in the hospital. When my dad was a child, Warren would bring him along on drives to the Twin Cities. My dad recalls how, on these trips, Warren packed the trunk with cash, as he was tasked with moving paper money from his family's bank to the financial hub of Minneapolis-St. Paul. When my dad was still a child and living at home, Leone kicked Warren out of the home and piled his belongings on the sidewalk. Warren then bought and moved into a new home within a half-mile from Leone. Despite the physical distance between their homes, Leone cooked and otherwise cared for Warren until he died. As with Meghan, the burdens of care largely fell on Leone, the most prominent woman in Warren's life.

Warren declined to help finance his children's higher education pursuits. He once asked my dad, who paid his own way through undergraduate and medical school with work earnings and loans, what my dad thought a bachelor's of science, or a B.S., degree stood for. When my dad replied that he was not certain what Warren was asking, Warren responded, "It stands for bullshit." Warren also would not accept my dad's conversion from Lutheranism to Catholicism upon marrying my mom. When he died, Warren signed over his part ownership of the bank to his nieces and nephews rather than to his own children. He named my dad executor of the remainder of his estate. My dad was stunned to find that, given Warren's lifelong frugality, and even without the bank holdings, Warren died a millionaire.

I recall family road trips to visit Warren and Leone. My brother, myself, and our large brood of cousins, enjoyed the days playing and running back-and-forth between Warren and

Leone’s homes. We assumed it was normal that our grandparents lived separately. After all, they still spent most of their waking hours together, so they must have loved each other. I did not know until adulthood, when I thought to ask, that the two were legally divorced. When we visited Warren at his home during the summer months, we would often find him sitting in the summer heat on the front porch, drinking from an unlabeled tin can, and spraying swarming bugs with Raid. Only later was I made aware that he was drinking hard alcohol from that can, and that this drinking, and his now advanced negative psychotic symptoms, precluded significant social interaction.

It is safe to say that life with Warren - for his wife, his children, and his extended family - was not easy. But, here’s the thing. The family adapted and, ultimately, thrived. They grew up in a relatively affordable place. Today, the median home price in their hometown is approximately $300,000. Both Warren and Leone purchased, and paid off, home mortgages on single salaries. The family also had adequate means at their disposal, including an asylum for Warren to stay at when needed. The children graduated from college, built careers, and started their own families.

By the time I was growing up, Warren’s children told a very different narrative about his life. They described Warren as a model of gruff, small-town, soft-spoken America. He was a beloved family figure – a steady fixture at family gatherings, an avid fisherman, a lover of lutefisk – and his home was a hub for family socializing. Despite his taciturn nature, he was an early internet adopter and an inspired emailer. After sending an email, he would call the recipient to ensure that the message had made it across the river nearby his home.

Although Warren would not say it, he was evidently dependent. He relied on his wife, nuclear family, and broader community for social support and sustenance. Through Warren, I witnessed firsthand how factors such as affordable housing, supported employment, and an accepting community could contribute to a fulfilling life. I do not believe that I would be here today had he not received such assistance.

I often think about Warren when I treat individuals with psychotic mental illnesses in my psychiatric practice, in particular those who have functional limitations. I wonder what it might take for them to not only survive, but to thrive. This curiosity pushes me to use illuminating anthropological theory and methods, in combination with my psychiatric clinical training, to do something about the cracks through which psychotic and dependent patients fall in the mental health system and social safety net (Bromley et al. 2015).

To this end, I lead authored an essay based in observational case study and Durkheimian and Foucauldian theory, and which advocates for the use of dispositional capacity assessments to address cognitive and functional limitations that might preclude safe hospital discharge (B. R. Erickson et al. 2022) (see Appendix A). I also lead authored an article based in semi-structured interview data and inductive thematic analysis, and which promotes patients' perspectives and preferences on how they might best be helped by structural reforms (B. R. Erickson, Marti, et al. 2023) (see Appendix B). I wrote an essay based on primary source research that advocates for the development of mental health infrastructure for the treatment of serious mental illness (B. Erickson 2021) (see Appendix C). I lead authored a review article based on clinical experience, and drawing from structural vulnerability and value-concordant care research, that calls for the formalization of street medicine and other low-threshold setting prescribing practices for patient benefit and safety (B. R. Erickson, Ehrie, et al. 2023) (see Appendix D). And, I co-authored an essay based in Foucauldian theory, and which advocates for patients with criminal records (Pope et al. 2022) (see Appendix E). I have also authored several letters, including one that advocates for medical care for psychiatric emergency room patients (B. Erickson, Landry, and Ehrie 2021), and another that mediates professional disputes that unnecessarily divide psychiatrists and allied professionals in treating and caring for serious mental illness (B. R. Erickson, Ehrie, and Goldman 2023).

I continued this line of observational and interventional thinking in this dissertation. I began with historical context on prominent issues of psychosis and dependency in a sub-population of those diagnosed with serious mental illness (Chapter 1). I illustrated the ways in which the mental illness symptoms of psychotic and dependent persons are shaped by the spaces – homes, hospitals, jails and prisons, streets – in which they live (Chapter 2). I explored the discretionary role of the police in detaining psychiatrically decompensated, gravely disabled, and possibly violent individuals (Chapter 3). And, I hypothesized social mechanisms that might contribute to a lethal neglect of psychotic and dependent persons (Chapter 4).

When I look back on Warren's life, I am struck by how much of his story I see in Brian, and how much of our family's story I see in Meghan. I wonder what might have happened if, like Brian, Warren was born in the 1980s. Had this been the case, and barring a significant violent offense, Warren would likely not have had access to a long-stay asylum. Would Warren have become a husband and a father? Would his family still have provided him with flexible work opportunities? Would he have had the means to buy a home when my grandmother, Leone, kicked him out?

We last see Brian as he exits jail with a criminal record for assaulting a police officer. His mother Meghan, a NAMI advocate and homeowner, laments that she might need to sell her home to cover the family's expenses. She forebodingly states, "Maybe he [Brian] needs to be homeless for a week or two [in order to appreciate what he has]." Here, Megan provides an extraordinary glimpse into a lethal neglect logic that, when combined with an American system of fragmented, hollowed out, and uncoordinated community psychiatric care for persons with serious mental illness, could dictate the remainder of Brian's life, as well as his eventual death - a logic that justifies Brian's potential abandonment to the whims of the neoliberal, capitalist political economic system in which Meghan, herself, fights to survive.

What might it take to prevent Brian from ending up like Stewart and Kelly, who die on the streets? How might each psychotic and dependent person - regardless of their class, race, and gender – live a fulfilled life like Warren? Moreover, how might care burdens be born equitably by families, communities, and institutions rather than fall disproportionately to women like Meghan and Leone? I offer no easy answers. However, I do assert that, with history in mind, and through stories such as Brian's, we – patients, family, friends, medical professionals, and academics – can learn to collectively provide individualized supports for those in need.

PART 2

Appendix A

A Case for Psychiatric Leadership in Dispositional Capacity Assessment

Blake R. Erickson, M.D., M.A., Joseph Pereira, M.D., Elizabeth Bromley, M.D., Ph.D., Leah G. Pope, Ph.D., Milton L. Wainberg, M.D.

Dispositional capacity assessment, which evaluates a patient's ability for self-care after hospital discharge, is a novel concept with important implications for work in consultation-liaison, inpatient, and emergency psychiatric settings. In this Open Forum, the authors present an illustrative case, review literature relevant to dispositional capacity, and explore social theory that elucidates the concept. Psychiatrists are specifically positioned to provide leadership in this area. Psychiatrists should consider further developing and formalizing criteria for dispositional capacity assessment.

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Tony (not a real name; other details in the following vignette were altered to protect patient privacy) was an elderly man brought by ambulance to the emergency department. Upon arrival, he requested discharge. He did not have his home keys and was unable to provide basic information, including his address or collateral contacts. He was seen by an emergency psychiatrist, received oral and intramuscular antipsychotic medications for agitation, and was admitted to the internal medicine ward for delirium. The primary medicine team consulted a consultation-liaison psychiatry team for further assessment. The consultation team documented differential diagnoses of delirium and unspecified dementia, with rule-out diagnoses including opioid, benzodiazepine, and alcohol use disorders. The team's recommendations included thiamine and folate supplementation, as-needed antipsychotic medications for agitation, monitoring for opioid and alcohol withdrawal, delirium precautions, and gathering collateral information about family, friends, and other close relations. The consultation team concluded that Tony lacked decisional capacity to leave against medical advice. They recommended that he be continuously monitored by both a clinical observer and a security guard.

Several days later, Tony continued to request discharge home. He eventually shared that his wife had recently died. He admitted to using heroin and illicit clonazepam before hospital presentation. He still could not recall his address or provide information about next of kin or friends. The psychiatry team completed a Montreal Cognitive Assessment (MoCA), which indicated a score of 18 of 30 (on a scale where higher scores indicate better cognition), with particular deficits in executive function. A CT scan of the head revealed mild-to-moderate volume loss in the brain. The primary medicine team then asked the consulting psychiatry team to comment on Tony's capacity to safely discharge home. The psychiatry team declined to comment, reasoning that such a future-oriented and multivariate assessment could not be made with the limited clinical data available. The psychiatry team recommended occupational therapy assessment and again encouraged the primary medicine team to obtain collateral information. An occupational therapist completed a Kettle Test, on which Tony scored 7 of 52 (higher scores indicate greater cognitive impairment). Ultimately, the primary medicine team contacted Tony's neighbor, who confirmed that she had called 911 after finding Tony in an unresponsive state. Tony was medically cleared, given a naloxone prescription, and discharged with transportation directly home. He declined substance use rehabilitation treatment. Social work referred him to visiting nursing services and a home health aide.

DISPOSITIONAL CAPACITY IN PRACTICE

Psychiatrists routinely complete decisional capacity assessments. Appelbaum's criteria (1) guide questioning and documentation of a patient's ability to communicate choice, understand information, appreciate consequences, and reason through options. These assessments are unidimensional and cross-sectional; they gauge capacity to make a discrete, binary decision at present. Bourgeois et al. (2, 3) coined the term *dispositional capacity* in 2017. The term is defined as "the assessment to determine the patient's capacity for self-management postdischarge" (2). Dispositional capacity is multifactorial and prospective and involves envisioning a patient's ability to care for self in the community and in the future.

Researchers have developed tools that aid clinicians when considering discharge options for hospitalized patients. Although no formal guidelines specify which cognitive assessment to use, clinicians often refer to the MoCA or the Folstein Mini-Mental State Examination. Functional assessments include the Assessment of Capacity for Everyday Decision-Making, MacArthur Competency Assessment Tool for Treatment, Langley-Porter Physical Self-Maintenance Scale, and the Instrumental Activities of Daily Living Scale (4, 5).

Bourgeois et al. (2) state that, "It is timely to more fully integrate a standard approach to cases presenting with concerns over decisional capacity and dispositional capacity. A clinical practice of . . . 'only answering the [decisional] capacity question' is limited and problematic, and represents a lost opportunity to fully engage in comprehensive patient care." This view echoes calls from geriatric care clinicians to develop formal metrics for capacity assessments (6). It also illuminates disposition dilemmas such as Tony's, in which primary medical and social work teams do not have a defined clinical pathway to follow. There are clear opportunities here for psychiatric involvement in making decisional capacity assessments, synthesizing biopsychosocial data, recommending cognitive and functional assessments, and coordinating multiteam disposition efforts. This is particularly the case for patients who lack decisional capacity and are without designated surrogates or advance directives. This population currently comprises 16% of intensive care patients and 3% of nursing home residents (7).

SOCIAL THEORY AND DISPOSITIONAL CAPACITY ASSESSMENT

We argue that psychiatrists should own, rather than defer, the responsibilities of dispositional capacity assessment. Perspectives from social theory and the psychiatric literature provide theoretical context for this complex issue. Sociologist Emile Durkheim's (8) notion of anomie is pertinent to this discussion. Anomie refers to a mismatch between individual action and social norms. The anomic individual does not or is unable to ascribe to the oft-unspoken social ethic. The individual thus repeatedly breaks moral and legal standards (9). The unspoken and unable aspects of anomie are further elucidated by social theories of governmentality and biopower. Fundamentally, these theories refer to a person's ability to internalize social standards in a way that allows for self-governance of health and well-being—that allows an individual to function independently without significant external aid (10).

In cases like Tony's, part of what unsettles us as physicians interested in efficient treatment and discharge, is that an anomic individual, such as an elderly person with delirium, likely dementia, a history of substance use, precarious social connections, and a questionable ability to self-govern, has presented to the hospital. Tony is without kinship—the solidarity "mediated by blood and marriage" (9)—that connects a person to beholden others, provides "the first line of defense against misfortune" (9), and serves as the foundation for national social security. Fortunately, Tony has a collection of what Columbia anthropologist Kim Hopper (9) refers to colloquially as "but fors." These "but fors" include the solicitousness of a neighbor and the diligence of the hospital providers. These connections constitute the difference between his marginal status and life in a "zone of social abandonment" (11)—what Princeton anthropologist João Biehl (11) describes as "places where the mentally ill and homeless, . . . the unproductive young, and old bodies" live and die.

In clinical cases where "organic impairment and past history interfere and pose a threat to health," dilemmas frequently arise regarding how to preserve autonomy (12, 13). Cohen et al. (12) exemplify this dilemma when they bluntly state that the "elderly, noncompliant rootless individual" can be "impossible to treat." Hamann et al. (14) echo that statement by observing, "The combination of marked participation preferences and impairments in the decisional capacity of individuals with aMCI [amnestic mild cognitive impairment] and early AD [Alzheimer's disease] constitute an ethical and practical challenge." Auerswald et al. (15) add that "delirium poses unique ethical challenges to the informed consent process, notably the preservation of patient autonomy in the face of potentially fluctuating decision-making capacity." This is especially true in cases of delirium superimposed on premorbid dementia, a relatively common presentation in hospitalized individuals ages >65 (16, 17). Of note, the delirium overlay is often preventable with reasonable precautions, including orientation, mobilization, and avoidance of psychoactive medications (17). Perhaps, psychiatric involvement through dispositional capacity assessment could provide a space to acknowledge and ameliorate such dilemmas.

AN OPPORTUNITY FOR PSYCHIATRIC LEADERSHIP

What are the clinical possibilities for advancing Bourgeois et al.'s (2) foundational work and developing dispositional capacity criteria akin to that of Appelbaum's (1) decisional capacity criteria? This development might entail a codified, encompassing mix of qualitative and quantitative data that allow clinicians to make assessments that can be communicated across practice settings (i.e., psychiatry to internal medicine), hospital, and regional contexts. A start could be delineating a practical clinical pathway for making such assessments (see table in an online supplement to this Open Forum). As Bourgeois et al. (2) advocate, dispositional capacity assessment might be conceptualized as comprising both decisional and performative components. In addition to weighing the risks and benefits of home versus another disposition, clinicians should be aware that a patient would need to demonstrate adequate cognitive and functional skills before being discharged home.

To begin such an assessment, a psychiatrist could complete a psychiatric evaluation, decisional capacity assessment, and formal cognitive testing (e.g., MoCA). A social worker could obtain clinically relevant information about past function and possibly perform an in situ evaluation (e.g., a home visit). Occupational and physical therapists could tailor their assessments to comment on a patient's ability to complete activities of daily living. The treatment teams could then convene to discuss an appropriate disposition to match the patient's cognitive and physical capacities. The psychiatrist could document the dispositional capacity assessment, including a synthesis of the above data. The primary team physician, if different from the assessing psychiatrist, could make the final dispositional decision. The social worker could then arrange aftercare. With further research, perhaps patients could be assigned quantitative disposition scores, which could be compared with evidence-based average scores for different dispositions.

What are the potential implications for psychiatry in taking a leading role in this effort? Beyond filling a functional clinical role, dispositional capacity assessment has potential as an intervention on social determinants of health. It is a concrete procedure that can connect individualized patient care to broader calls for social inquiry. With a holistic dispositional capacity assessment, the psychiatrist has an opportunity to pause and convene a multidisciplinary team. They can consider the ways in which not only financial means and social supports but also factors such as race and gender might affect a patient's postdischarge trajectory. Engaging in such a value-driven, protocolized, and team-based assessment could both decrease stress of primary medicine teams around discharge and thoughtfully match patients with complex neuropsychiatric conditions to disposition options.

Although some providers within psychiatry may prefer to defer dispositional capacity assessments to social work, dilemmas regarding the balance between autonomy and beneficence will continue to emerge in routine clinical care. Social workers are experts in identifying social supports and arranging aftercare. Psychiatrists are uniquely trained in performing decisional capacity assessments, developing differential diagnoses, and providing treatments. These decisional and clinical assessments are central to dispositional capacity determination. As default team leaders and clinical experts, psychiatrists should consider researching, codifying, and disseminating dispositional capacity criteria.

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Appendix B

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BRIEF REPORT

"They Just Helped Save My Life:" Client Perspectives on the Los Angeles County Full Service Partnership (FSP) Program for Serious Mental Illness

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Abstract
The purpose of this qualitative study was to elicit client perspectives on the Los Angeles County Full Service Partnership (FSP) program - an adaptation of Assertive Community Treatment (ACT). Semi-structured interviews were conducted with 20 FSP clients. Qualitative data were analyzed using thematic analysis. Two major themes were identified from the interview data: (1) Clients' acknowledgement of the material benefits of the FSP program; and (2) FSP's impact on restoring and stabilizing clients' social and treatment relationships. Interviewees greatly valued the material (i.e., basic needs, housing assistance) and relational (i.e., relationships with providers, restored personal relationships) aspects of the program, but did not ascribe the same degree of value to mental health treatment. Interviewees' emphases on material and relational aspects reflect the status of assertive mental health treatment as an intervention on intermediary determinants of health in the lives of persons diagnosed with serious mental illness.

Keywords Full Service Partnership (FSP) · Patient-Centered Treatment · Assertive Mental Health Treatment · Social Determinants of Health

Introduction

Serious mental illnesses (SMI) (e.g., schizophrenia, bipolar disorder) affect 5.6% of adults in the United States and can be associated with significant functional impairment (Substance Abuse and Mental Health Services Administration, 2021). Evidence suggests that individuals with SMI frequently experience co-occurring substance use disorders, housing instability or homelessness, violence victimization, relational instability, criminal justice involvement, and physical illness (Elbogen et al., 2021; Hunt et al., 2018). On average, there is a 10- to 20-year mortality gap between those who do and do not have SMI. This gap is driven by factors such as greater rates of untreated chronic medical illness, higher rates of suicide, and inadequate basic needs support (Parks et al., 2006).

An evidence-supported approach to addressing whole-person needs for individuals with SMI in community settings is Assertive Community Treatment (ACT) (Bond et al., 2012; Spivak et al., 2019). ACT emerged in the 1970s as a community-based program for individuals exiting long-stay

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psychiatric hospitals. ACT sought to bring mental health treatment into community settings, to meet basic needs (i.e. food, clothing, shelter, transportation), and to prevent crises and re-hospitalizations. The model grew to include multidisciplinary staffing (i.e. psychiatrist, nurse, therapist, case manager, substance abuse counselor, and employment coach), an integration of services through team-based approaches, low client-staff ratios that ensure the intensity of service delivery, assertive outreach and proactive medication management, and rapid and flexible responses to clients' concerns and crises (Bond et al., 2012; Test & Stein, 1976). ACT has been tested in 25 randomized controlled trials, which show positive client outcomes in terms of psychiatric hospitalization rates, housing stability, psychiatric symptomatology, treatment engagement, and quality of life (Bond et al., 2012; Nelson et al., 2007). Qualitative interviews with ACT clients indicate that the establishment of trusting relationships with service providers is one of the most beneficial aspects of the program. This relational foundation motivates client treatment engagement and contributes to stability in other areas of life (Davidson, 2003; Leiphart & Barnes, 2005).

While the ACT model proved effective in sustaining clients in the community, practical and financial difficulties (Odden et al., 2019) in adhering to high-fidelity (Rosen et al., 2007; Stanhope & Matejkowski, 2010; Teague et al., 1998; Winter & Calsyn, 2000) ACT programming standards often led state and local governments to implement ACT-like programs, which did not aim to meet these fidelity marks. Such ACT adaptations are now more prevalent in the United States than high-fidelity ACT programs (Moser & Monroe-DeVita, 2019; Spivak et al., 2019). An example of an ACT adaptation is the Full Service Partnership (FSP) program in California. Passed in 2004, Proposition 63, or the California Mental Health Services Act (MHSA), enacts a 1% yearly tax on personal incomes greater than $1 million and generates approximately $1 billion per year for public mental health treatment in the state of California (California Mental Health Services Oversight & Accountability Commission, 2022). 60% of yearly MHSA funds are allocated toward FSP (Los Angeles County Department of Mental Health, 2022). FSP serves a racially diverse and financially disadvantaged adult population. In Los Angeles County, 24.3% of adult FSP clients identify as Hispanic, 33.0% as Black, 30.4% as non-Hispanic white, and 5.5% as Asian/Pacific Islander (Ashwood et al., 2018). FSP programs share many features of ACT, including enrollment of individuals living with SMI diagnoses and who experience homelessness, criminal justice system involvement, or frequent psychiatric hospitalization; high staff-to-client ratios; multidisciplinary treatment teams; and services delivered in the field rather than in the clinic. FSP programs provide medication management, linkages to substance abuse services, housing supports, and supports for daily living (ex. transportation, education, healthcare), with the underlying mission of sustaining clients in community living (Gilmer et al., 2010, 2013; Starks et al., 2017). In Los Angeles County, FSP programs differ from the ACT model in that visit frequency may be less than recommended in ACT and team staffing may not match ACT recommendations. The philosophical approach of FSP places a strong emphasis on client choice and client-driven recovery (Starks et al., 2017). In general, client-driven service models are defined by their prioritization of clients' treatment goals (ex. quality of life) in addition to providers' goals (ex. psychiatric medication adherence) (Comiskey et al., 2021; Fentress et al., 2021; Mancini, 2008).

There have been several evaluations of FSP program components, including peer support and housing assistance (Gilmer et al., 2013; Siantz et al., 2017). However, little is known about how FSP clients themselves experience the FSP program. The 1 mixed-methods evaluation (Starks et al., 2017) of the initial implementation of FSP made a substantial effort to gather client experiences through surveys and interviews. However, a summary publication (Starks et al., 2017) from this evaluation focused largely on quantitative indicators of program outcomes and included limited in-depth exploration of qualitative client experiences. This lack of client-centered evaluation of FSP in the literature is a significant gap for a client-driven program. To better understand client-centeredness in FSP programs, the present qualitative studyaimed to explore client perspectives and experiences with FSP in four major outcome domains: (1) relationships with family and friends; (2) employment, education, and volunteering; (3) basic needs, including housing, obtaining food, and receiving medical care; and (4) mental health treatment.

Methods

Design and Data

Data gathering for this qualitative and descriptive study took place in Los Angeles from November 2017 to January 2018 as part of a mixed-methods evaluation of FSP programs run by the Los Angeles County Department of Mental Health (Ashwood et al., 2018).

Sample

The FSP program in Los Angeles County serves approximately 7,000 adults (Los Angeles County Department of Mental Health, 2022). Convenience sampling was used to recruit clients who had participated in the FSP program for at least 6 months. Flyers were emailed to 16 of 183 FSP clinic sites across Los Angeles County. These sites were selected in collaboration with Los Angeles County Department of Mental Health leadership as the sites serve large numbers of FSP clients and were willing to participate in qualitative evaluation activities. Forty-eight interested clients left a voice-mail at a dedicated study phone number. The research team attempted to contact each client who left a voice-mail. In 28 cases, the contact number was disconnected or the client did not answer after multiple attempts. The final study sample was 20 clients from 7 FSP sites.

Procedures

Informed consent was obtained from all interview participants or their legal guardians, if applicable, prior to the interview. Three authors (BE, FM, KC) conducted semi-structured phone interviews with participants, which lasted from 20 minutes to 2 hours. Interviews began with an open-ended 'grand tour' question to encourage interviewee sharing of lived experiences with the FSP program. Participants were asked questions about the impact of FSP enrollment on 4 major domains of life function: (1) relationships with family and friends; (2) employment, education, and volunteering; (3) basic needs, including housing, obtaining food, and receiving medical care; and (4) mental health treatment. Participants were encouraged to elaborate on their own understandings of each area of impact and were also asked how their FSP programs could improve in meeting their needs in these areas. Interviewers used a topic grid to ensure that all relevant areas were covered in the order preferred by interviewees. Each interview was audio-recorded and professionally transcribed prior to analysis.

Data Analysis

Thematic analysis was used to derive themes from interview data (Braun & Clarke, 2006, 2012). One author (BE) read each interview and organized participant responses into each of the 4 major domains of impact explored in the interviews (relationships with family and friends; employment, education, and volunteering; basic needs; mental health treatment) using ATLAS.ti software. Then, 2 authors (BE, BB) used inductive thematic analysis to identify underlying themes within and across each of the 4 major domains (Braun & Clarke, 2006). Coders first reviewed interview transcripts for data familiarization. Then, each interview was systematically coded for meaningful segments of data. Authors BE and BB met to compile groups of codes and construct themes from meaningful code clusters. Candidate themes were then reviewed with the full authorship team to develop final themes with central organizing concepts.

Conflict of Interest, Institutional Review Board, Author Certifications

The authors report no financial relationships with commercial interests or other conflicts of interest in the completion of this study. This work was supported by the California Mental Health Services Authority, with funds provided by the Los Angeles County Department of Mental Health, who had no involvement in study design; in the collection, analysis, and interpretation of data; or in the decision to submit the article for publication.

The study was approved by the RAND Institutional Review Board.

All authors certify their responsibility for this manuscript.

Results

Sample Description

Twenty clients from 7 sites enrolled in the study. All but 2 clients had been in their FSP program for over a year. Across enrolled clients, average time in program was 5.5 years (SD 7.7 years; range 7 months to 10 years). Average client age was 48.7 years (S.D. 13; range 21 to 72 years). Twelve participants self-identified as female and 8 as male.

Interview Themes

Two major themes were identified from interview data: (1) Clients' acknowledgement of the material benefits of the FSP program; and (2) FSP's impact on restoring and stabilizing clients' relationships. At the beginning of each interview, interviewees were asked to respond to an open-ended question regarding the single most salient aspect of FSP to their lives. 40% of interviewees (n = 8) emphasized material aspects of the program, including basic needs care and housing. 35% (n = 7) emphasized relational aspects of the program, including improving or creating new relationships with providers, other staff, family, and friends.

A minority of the sample (25%, n = 5) emphasized mental health-specific benefits such as diagnosis and treatment. Most interviewees discussed the relational and material benefits of FSP even when asked about mental health treatment. Interviewees provided only passing commentary, and little to no detail, on the impacts of psychiatric medications and other mental health-specific treatments. They incorporated comments on medication management and therapy into discussions of the benefits and drawbacks of relationships with psychiatrists, psychologists, nurses, case managers, and other FSP staff members. Below, we further summarize, as well as provide illustrative quotes for, the interviewee-elicited themes of material and relational benefits.

Theme: Clients' Acknowledgement of the Material Benefits of the FSP Program

All interviewees commented on the significance of material assistance provided by their FSP programs. Interviewees reported receiving a spectrum of basic needs support including clothing, furniture and appliances, laundry, food, cleaning, cooking, showers, medical care, legal services, transportation, and banking assistance. Interviewees spoke of the necessity of having basic needs met prior to realizing other goals such as repairing relationships, obtaining employment, and enrolling in school. From the perspective of participants, the FSP programs built a foundation to realize these goals.

Most interviewees were or had recently been homeless for periods of months to years. In reflecting on the role of FSP in meeting basic needs, many participants emphasized that receiving housing assistance from their FSP programs was the most meaningful material benefit. Some reported receiving assistance managing money to pay rent, applying for and obtaining social security disability insurance, and obtaining loans to make housing payments. One interviewee shared:

> (Client 1) When I came out of jail, I didn't have anywhere to stay and I was out on the streets. So, this really helped save my life […] because I was going through some mental issues and needed my medication. […] [My FSP program] helped me get back on my medication and they helped me find housing. That's how I got on a team and I've been going there for a while. They really helped save my life because I didn't really know anything about what to do at that time, because I was just stranded. I had to go to a DUI [driving under the influence] class. I had a little bit of money. I didn't have a place to stay. I lost my car in impound, so I was living on the streets […] They just helped save my life.

Interviewees also described receiving assistance from their FSPs in registering for classes at local colleges and trade schools as well as applying to jobs. Some worked part-time at their FSP as a form of job training (e.g. secretarial duties, cafeteria work). Several interviewees described these training opportunities as playing central roles in their future material security.

Theme: FSP's Impact on Restoring and Stabilizing Clients' Relationships

All interviewees commented on the salience of relational aspects of their FSP programs. This theme included 2 sub-themes: first, highlighting the impact of FSP in assisting in the repair of old relationships and the establishment of new relationships with family and friends; and second, emphasizing the importance of relationships with FSP staff to client wellbeing and recovery, though finding staff turnover to be a major barrier to relational stability.

Sub-theme: Repairing and Rebuilding Personal Relationships Interviewees commented on the ways in which FSP interventions, such as housing assistance, medication management, and treatment for substance use disorders helped them to revitalize relationships with family and friends. One interviewee described the impact that housing assistance had on his relationships with family members:

> (Client 2) It actually gave me the ability to kind of complete that family unit. […] The first time I got my own apartment […] was very significant. That was my first, first. Like, 'Oh, I got to go to sleep in peace because my kid's right here next to me.' So [my FSP] gave me that opportunity to actually start my family up. You know, have constant and […] consistent visits with my child, be a part of his life. Have my mother over more, so our dynamic smoothed over. Things became a lot more peaceful between my mother and I. She saw I was doing things that I should be doing.

Several interviewees credited FSP with helping them end abusive relationships. One described her experience working with a FSP psychologist to end a relationship:

> (Client 3) The relationship that I was in, how depressing it was, how unsupportive it was and how it was just a go-nowhere relationship. Like areas that I'm working on for myself is self-esteem and setting boundaries but I couldn't set any boundaries with somebody who was verbally abusing me and psychologically abusing me. I couldn't hardly build any self-esteem with that type of relationship, either […] The psychologist helped me […] She used to tell me different ways of looking at it and different things that turn out and just how abusive - those things never get better, they only get worse. And I think, I don't know, it helped me realize how … I don't know. I wanted to move on in my life. I knew that I had to get out of that relationship to move on. So, so far, I've been able to.

Interviewees also sought out and formed relationships with other FSP clients. These relationships provided social support and awareness of others' experiences with mental illness. These connections reassured interviewees that their own mental health and other personal strivings were understood.

Sub-theme: Meaningful Relationships with Service Providers Complicated by Staff Turnover Interviewees' comments on therapy focused on the relational aspects of FSP. Interviewees described a variety of ways in which therapy (e.g., goal-directed talk therapy, group therapy) provided by FSP programs helped them cope with daily challenges, maintain connections with others, and defuse stressful situations. One interviewee described her weekly talk therapy as an exercise that: (Client 4) Assists me with moving forward and improving the quality of my life. [Therapy provides a] 'toolkit' [of strategies for] personal engagement, trauma, barriers, goals, hopes, dreams, fun, balance.

Interviewees strongly emphasized the importance of attentive, trusting, and respectful relationships with FSP staff (in particular, psychiatrists, psychologists, case managers, and nurses). Some went so far as to describe client-staff relationships as dependable and family-like in nature. One client shared: (Client 5) I feel comfortable. I feel that I can go ahead and let them [program staff] know whatever is on my mind, whatever is bothering me […] I do have a place of support all day if I want, every day.

Interviewees expressed strong opinions about the ways in which relationships with staff could be improved, chiefly through continuity in client-staff relationships. Interviewees indicated that promises made by staff should be kept if and when possible, particularly those related to services such as housing. Interviewees repeatedly raised concerns over the issue of staff turnover. The extent of this problem can be seen in one interviewee's comment that: (Client 6) [My FSP] is very fluid. One week you'll come and you'll know everybody and the next week, you don't recognize a face.

Interviewees requested the opportunity to provide input on the staff make-up of their FSP teams, to be treated respectfully by staff (e.g., not being spoken to firmly; not being talked down to), and to have more face-time with FSP providers, particularly psychiatrists and psychologists. Interviewees asked for more provider hires in order to meet client demand for therapy and medications as well as more group programming.

Discussion

This study explored clients' perspectives of an ACT adaptation, the Los Angeles County FSP program. Interviewees noted material interventions (e.g., safe and long-term housing) and interpersonal programmatic aspects (e.g., relationships between clients and their providers, other staff, peers, and family members) to be the most beneficial elements of the FSP program. Interviewees generally did not emphasize benefits from psychotropic medication treatment, though some did speak positively about therapy. The FSP program intends to promote community stability for individuals with SMI through intensive psychiatric treatment and wraparound services (Los Angeles County Department of Mental Health, 2022). While providers often prioritize psychotropic medication adherence in maintaining such stability (Pyne et al., 2006), client interviewees in the present study clearly conveyed that social supports – in the way of basic needs resources and relationships - are the most beneficial aspects for them. Of note, this finding of basic needs as a client priority in FSP contrasts with findings of a previous mixed-methods evaluation, which focused its client questioning more narrowly on mental health treatment (Starks et al., 2017).

Interviewees' emphases on these material and relational aspects echo arguments made by the World Health Organization (WHO) about the significance of intermediary determinants of health (World Health Organization, 2010). The WHO describes structural determinants of health as the macroeconomic, social, and public policies, as well as cultural and societal values, that produce health inequities structured around race, gender, class, education, occupation, and income. Structural determinants operate through downstream intermediary determinants, including material (housing and basic needs care) and psychosocial (social support) circumstances, to produce health outcomes (Brooke-Sumner et al., 2015; Menear & Briand, 2014; World Health Organization, 2010). ACT adaptations like FSP could be understood as interventions on such intermediary factors. FSPs impact health by creating a downstream buffer against structural inequalities and deprivations. From the perspectives of FSP clients with SMI in this study, addressing such intermediary factors was essential to ensuring mental well-being and was perceived as possibly more important than direct psychiatric services. In effect, through an income tax on wealthy Californians, the FSP program redistributes societal resources to build community mental health infrastructure (Erickson, 2021); it thus provides thousands of persons with intensive mental health treatment and basic needs care.

Although clients spoke positively about the meaningful relationships they developed with FSP providers and staff, staff turnover was a major source of dissatisfaction and relational instability for clients within the program. Studies suggest that staff turnover in mental care health is high in general, estimated at 25–50% per year, and that this turnover contributes to challenges with care continuity and quality (Brabson et al., 2020; Woltmann et al., 2008). Turnover is associated with reduced provider productivity, fractured client-provider relationships, fragmented clinical teams, extra costs to treatment organizations, client non-attendance, and reduced evidence-based practice (Babbar et al., 2018; Brandt et al., 2016). Therapeutic relationships can be important sources of relational stability and mental health staff play key roles in building trust between clients and service organizations (Davidson, 2003). For vulnerable populations such as those affected by SMI, FSP programs could consider making every effort – whether through increased employee pay or improved benefits - to reduce staff turnover and promote consistent therapeutic relationships. In a FSP setting where interviewees describe their programs and providers in home and family-like ways, client-provider relationships could be treated and understood as fundamental to client-centered assertive treatment (Angell, 2003).

Another way that FSPs might embrace a more client-centered approach could be to prioritize material needs, both since mental well-being is difficult, if not impossible, when basic needs go unmet, and also because prior studies have consistently found that client satisfaction with mental health treatment is highest when support for practical needs are fulfilled and client values are honored (Alegría et al., 2018; Gilmer et al., 2013; Leiphart & Barnes, 2005). Findings from interviews in the present study suggest that assertive mental health treatment could reflect clients' values by explicitly framing itself as an intervention on intermediary determinants of health. Material basic needs supports, from housing to furniture to healthcare, could be viewed as core functions, not the penumbra, of such assertive treatment. Material supports could be expected to be robust and adaptable to the point of sheltering and supporting individuals who have nowhere else to turn. Programs that do not provide adequate material supports could be *de facto* viewed as falling short of client-centeredness (Williamson, 2002).

Finally, client-centered assertive treatment could emphasize long-term, wraparound care to meet and sustain basic needs and relational supports. This runs counter to recent arguments that assertive mental health treatment programs like FSP should be time-limited or should prioritize transitioning to less intensive services (Bromley et al., 2017; Donahue et al., 2012). Participants in the present study viewed the FSP program as aimed toward equity and community, rather than focused solely on mental illness treatment. Given the critical impact of basic needs services on clients' mental and physical health, approaches to considering individuals' readiness for transitioning out of such programs could consider not only improvements in mental health symptoms and physical health status, but also individuals' abilities to live as long-term, engaged members of the community outside of the program (Williamson, 2002).

Limitations

This study used a convenience sample of interviewees from 7 FSP sites in a single geographic region. Multiple clients who expressed initial interest in study participation could subsequently not be reached via telephone outreach. As such, the perspectives of individuals in the interview sample may not reflect the full range of client experiences within all FSP programs. Given the geographic and programmatic focus of this evaluation, perspectives on FSP programs may not be transferrable to other ACT adaptations and/or ACT itself in other geographic locations.

Conclusion

Through analysis of client interview data drawn from an evaluation of FSP programs, this paper explores questions of client-centeredness within FSP. Intentional prioritization of 2 FSP programmatic components identified by FSP client interviewees - material and relational supports - could produce more client-centered FSP care. Nationwide emphasis on these priorities could unify FSP and other ACT adaptations as interventions on intermediary determinants of health, or interventions that intentionally redistribute social and material resources and ameliorate the negative impact of structural determinants that undermine the health and wellbeing of many persons living with SMI. Such a paradigm shift has the potential to impact the ways in which ACT adaptations are envisioned, in particular by moving away from thinking about assertive mental health treatment in terms of therapeutic clinical efficacy and toward a foregrounding of clients' understandings of beneficial care.

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Formal analysis and investigation, Funding acquisition, Resources; Elizabeth Bromley: Conceptualization, Methodology, Formal analysis and investigation, Writing – original draft preparation, reviewing and editing, Funding acquisition, Resources, Supervision.

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Appendix C

ARTICLE

Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963

Blake Erickson, M.D., M.A.

One Flew Over the Cuckoo's Nest, *The Snake Pit*, *The Shame of the States*, "Titicut Follies," and *Life Magazine*'s "Bedlam 1946": these articles, films, and books—and books that were made into films—are cultural touchstones of the state mental hospital era. They epitomize a negativism—regarding insanity, imprisonment, terror, chaos, and disgrace—associated with life in American psychiatric institutions in the first half of the 20th century (1, 2). Although critical attention has been paid to the relationship between publicized atrocities and the movement for state hospital deinstitutionalization, fewer efforts have highlighted the federal idealism underlying deinstitutionalization. The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963—more commonly known as the Community Mental Health Act (CMHA) (3)—provides a critical historical lesson on the roles of optimism and structure in outpatient care for serious mental illness.

In 1946, the federal government entered mental health policy with the passage of the National Mental Health Act. In 1949, it established the National Institute of Mental Health (NIMH). With both, the government promoted visions of progress and community in mental health care—a stark contrast to stagnant connotations of state hospital institutionalization (2). By the 1960s, in terms of policies from the environment to education, the public largely believed in the federal government's ability to meet society's needs (4). In this political context, the Joint Commission on Mental Illness and Health, a federal organization charged with surveying the resources and diagnostic and treatment methods for mental illness, published its findings as Action for Mental Health. This document detailed inadequacies in national mental health services and called for improvements in both state mental hospitals and community mental health care (2). In 1963, Congress then passed and President Kennedy signed the CMHA. With the CMHA, Kennedy and Congress sought to decrease the number of institutionalized individuals by incubating self-sufficient and local mental health care centers.

Kennedy's personal motivations illustrate the federal idealism in community mental health care. With his New Frontier platform, Kennedy sought improvements in the nation's mental and physical health. He also aimed to unburden society of chronically dependent persons. In particular, he hoped to liberate the population of confined mentally ill patients through advancements in psychopharmacology and supportive housing. He was emotionally drawn to issues of mental illness and intellectual disability because of his sister Rosemary, who underwent a lobotomy that significantly worsened her quality of life (2). Politically, Kennedy grasped the negative public sentiment around an increasing institutionalized population and its associated cost to the states. Kennedy's special message to Congress on February 6, 1963, captured his sense of optimism as he promoted a plan to, "Cut by half, within a decade or two, the 600,000 persons now institutionalized for psychological disorders" (5).

An overwhelmingly Democratic Congress (Senate 65% and House 59%) aligned with Kennedy on political and ideological sentiments (6). The Senate and House of Representatives introduced identical bills that outlined terms of temporary federal financial support for the initial construction and staffing of community mental health centers (2). Despite financial concerns, illustrated by a Bureau of Budget internal memo that read, "The real question is who is going to finance operating costs once the federal subsidies are ended or indeed if they can be ended" (2), bipartisan belief existed within both chambers that the CMHA's vision was a more hopeful and humanistic alternative to institutional care. This belief was rooted in a deep trust in medicine's promise to eliminate illness. Congressional members generally lacked medical knowledge, and many accepted claims about community mental health centers without probing (2). As preeminent mental health historian Gerald Grob wrote, a "euphoric atmosphere" (2) existed within Congress surrounding the possibilities of community mental health care. In the end, the Senate (72-1) and House (335-18) wholly approved the CMHA (2).

Apart from national politics, psychiatry was experiencing intraspecialty ideological discord in the 1960s. Those stressing biological influences on mental illness and those emphasizing social determinants and psychotherapy divided the field. As a collective profession, however, psychiatry sided with President Kennedy and Congress on the importance of enhancing community mental health care. With the recent development of medications, including chlorpromazine, reserpine, iproniazid, and imipramine, psychiatrists were optimistic that severe psychotic and mood states, previously viewed as recalcitrant to medical treatment, could be treated in community settings (1, 2). However, in a council position paper from the American Psychiatric Association (APA), the profession hedged on strengthening community mental health at the expense of state mental hospitals, which psychiatrists knew continued to care for patients with the most serious mental illnesses (2). APA president C. H. Hardin Branch best summarized the profession's overall stance in comments made at the APA's 119th annual meeting in St. Louis on May 6, 1963. In a *New York Times* article about the meeting, titled "Parley of Psychiatrists Hails Support of Mental-Health Plan," Branch commented on psychiatry's "double-barreled proposition." On the topic of community mental health care, he stated that there are "Great community acceptance, matching community demands and vast community opportunities. However, . . . this great amount of support is based on the assumption that psychiatry will be able to find answers to many social problems, rather than to continue merely to treat them . . . psychiatrists must try to distinguish between those areas in which social forces rather than psychiatric illness are at fault . . . then the psychiatrist must be willing to try to meet social needs and handle the wide range of psychiatric problems" (7). As illustrated in Branch's comments, many psychiatrists—and their elected leaders—rejoiced at the public attention being paid to mental illness. Yet these same psychiatrists cautioned that commitment to community models required mental health professionals to fully address the social problems—such as poor socialization and lack of housing, food, and clothing—that exacerbate mental illness in community settings.

The CMHA funded 3 years of federal grant payments to the states, totaling $150 million, for the physical construction and initial staffing of 1,500 community mental health centers to provide five essential services: consultation and education for community and professional organizations, inpatient facilities, outpatient clinics, emergency response, and partial hospitalization (2). Once enacted, however, the CMHA did not fulfill its optimistic promise. Ultimately, states built a variety of community mental health centers, producing a heterogeneity that made it difficult for NIMH to effectively assess and regulate. Local concerns often translated into treatment for those with less serious mental illnesses. This focus on persons who had little or no connection with prior state hospital care was at the expense of individuals who required assistance to function in daily life. Most community mental health centers, moreover, did not provide the expensive basic provisions that individuals with serious mental illness needed to live in the community (1, 2).

Because of construction and long-term funding impediments, states built approximately half of the 1,500 centers outlined in the CMHA (2). The nationwide state mental hospital census decreased by over 90% by the early 2000s (8), from a peak of 558,922 in 1955 (2). Individuals with diagnoses of serious mental illness were scattered across the mental health treatment system, with no single organization accepting longitudinal responsibility to address their basic needs. Funding for care fell to programs such as Supplemental Security Income, Social Security Disability Insurance, and food stamps. Because of age, financial, and bureaucratic application barriers, many did not qualify for Medicaid and Medicare, the landmark safety net insurance programs established in 1965 (1, 2). Care often fell to families, friends, and associates. Those without homes often ended up on the streets, with many entering an institutional circuit of acute care hospitals, jails, prisons, and forensic facilities (1).

An optimistic federal belief in locally sustained community mental health care in part drove deinstitutionalization. The CMHA and its failings teach us that optimism without infrastructure slows the path to success. Evidence-based outpatient programs, such as assertive community treatment, coordinated specialty care, and Housing First, channel the optimism of the CMHA (9–11). Such programs also counteract a modern atrocity of care: too little structure. We must provide the resources needed for each person with serious mental illness to thrive in an individualistic and meritocratic society. Perhaps this bit of healthy realism can continue to drive a movement as revolutionary as deinstitutionalization itself: the structuring of outpatient care for serious mental illness.

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Appendix D

A Rapid Review of "Low-Threshold" Psychiatric Medication Prescribing: Considerations for Street Medicine and Beyond

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Objective: No widely accepted clinical guidelines, and scant directly applicable pragmatic research, are available to guide the prescription of psychiatric medications in "low-threshold" outpatient settings, such as street outreach, urgent care, and crisis care, as well as walk-in, shelter, and bridge and transition clinics. Providers frequently prescribe medications in these settings without patients' having firm psychiatric diagnoses and without medical records to guide clinical decision making. Persons who receive medications in these settings often seek help voluntarily and intermittently for mental illness symptoms. However, because of structural and individual factors, such patients may not engage in longitudinal outpatient psychiatric care. The authors reviewed the literature on psychiatric medication prescribing in low-threshold settings and offer clinical considerations for such prescribing.

Methods: The authors conducted a rapid literature review (N=2,215 abstracts), which was augmented with up-to-date clinical prescribing literature, the authors' collective clinical experience, and *DSM-5* section II diagnostic criteria to provide considerations for prescribing medications in low-threshold settings.

Results: For individuals for whom diagnostic uncertainty is prominent, a symptom-based diagnostic and treatment approach may be best suited to weigh the risks and benefits of medication use in low-threshold settings. Practical considerations for treating patients with clinical presentations of psychosis and trauma, as well as mood, anxiety, and substance use disorders, in low-threshold settings are discussed.

Conclusions: An urgent need exists to invest in pragmatic research and guideline development to delineate best-practice prescribing in low-threshold settings.

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Throughout the 1990s and 2000s, psychopharmacologic development rapidly accelerated (1). Leading psychopharmacology manuals incorporated this medication armamentarium and offered detailed, evidence-based recommendations regarding medication dosages, routes, and adverse effects (2, 3). Professional consensus statements on psychoactive medication prescription were developed to represent the prevailing recommendations within the field of psychiatry (4–6). Despite these broad advances, guidelines for the practice of street psychiatry specifically, and prescribing in "low-threshold" outpatient settings more generally, remained largely obscure; this knowledge was most often gained and passed on through on-the-ground clinical work by practitioners (7).

Low-threshold medication prescribing practices were developed to treat people living in the community with serious mental illness, some of whom were homeless and unconnected to long-term outpatient psychiatric care (8–18). Theoretically, such practices enhance care equity. They provide voluntary psychiatric care in the form of prescription medications to disproportionately underresourced populations and structurally vulnerable persons, regardless

HIGHLIGHTS

- "Low-threshold" outpatient prescribing settings, including street outreach and shelter clinics, are those in which a medication recipient's psychiatric diagnosis may be unknown and collateral information may be unavailable at the time of prescribing.
- No prescribing guidelines and little to no research are available to inform the use of most medications in low-threshold settings.
- There is a need to invest in research and guideline development to delineate best-practice prescribing in low-threshold settings.

of their ability to pay (19). In practice, low-threshold-prescribing procedures work in conjunction with behavioral and other interventions, such as mobile and community-based outreach as well as care navigation and linkages, to increase access for hard-to-reach psychiatric patient populations.

Individuals receiving care in low-threshold-prescribing settings often do not have definitive psychiatric diagnoses or known psychiatric histories. These individuals are often not actively engaged in longitudinal outpatient care because of factors such as personal hesitancy, distrust, previous negative interactions with the mental health system, insurance or cost barriers, mental illness and substance use symptomatologies, and systemic limitations in care access, including structural racism. Low-threshold program models include street medicine, urgent care, mobile crisis, crisis stabilization, and crisis residential treatment, as well as shelter, walk-in, and bridge and transition clinics. In these dynamic settings, prescribers might not have access to basic clinical information, including medical record documentation, laboratory tests, vital signs, and collateral information. Critical auxiliary support, including social work and nursing, might be limited or absent (20). Although similar prescribing principles may apply in some emergency department settings, because emergency departments can provide involuntary care and obtain medical workups, for the purposes of this discussion, they were not considered to be low threshold.

With state and local health systems focusing their efforts on acute and subacute psychiatric crisis care (21), and the recent national implementation of the 988 Suicide & Crisis Lifeline, psychiatrists and other psychiatric practitioners (i.e., nurse practitioners, physician assistants, and others) working in such services are increasingly providing medications to historically underserved and understudied individuals. In doing so, providers confront an array of prescribing dilemmas without evidence-based guidelines (22, 23). To illuminate what is known and to identify existing knowledge gaps, this review highlights key prescribing challenges in low-threshold settings and offers considerations for psychiatric medication prescribing within these settings.

METHODS

We conducted a rapid literature review on prescribing practices in low-threshold settings. We limited the review to four major searchable databases (i.e., Google Scholar, PubMed [biomedical research], PsycINFO [psychological research], and Web of Science [science and technology research]). Searches were performed by combining terms from two groups, A and B. Each term in group A (street psychiatry psychiatric medication prescribing, street medicine psychiatric medication prescribing, nontraditional outpatient psychiatry psychiatric medication prescribing, low-threshold outpatient psychiatric medication prescribing, homeless psychiatric medication prescribing, bridge services psychiatric medication prescribing, urgent care psychiatric medication prescribing, and crisis care psychiatric medication prescribing) was combined with each term in group B (consensus statement, algorithm, tips, advice, guidelines, recommendations) to produce 48 unique search terms (e.g., "street psychiatry psychiatric medication prescribing consensus statement"). Each of these terms was used to search the four databases. General searches were conducted without restrictions on period or publication type. The first 20 abstracts, or as many abstracts as resulted from each search (range 0–20), were examined. In total, 2,215 abstracts were reviewed. Of these, two were directly relevant to the topic (22, 23). Neither of these two sources attempted a review of the relevant literature or commented in detail on the specifics of outpatient psychiatric medication prescribing in low-threshold settings.

We augmented our review with up-to-date literature on clinical prescribing standards. We used this literature and our collective clinical experience to offer specific considerations for prescribing medications in low-threshold settings. To develop these prescribing considerations, we used groupings based on *DSM-5* section II diagnostic criteria and codes ("schizophrenia spectrum and other psychotic disorders," "bipolar and related disorders," "depressive disorders," "anxiety disorders," "trauma- and stressor-related disorders," "substance-related and addictive disorders") as starting points to identify five symptom clusters (psychosis, mood, anxiety, trauma, and substance use) commonly encountered in low-threshold settings. As further detailed in the Results section, we used symptom clusters in lieu of formal *DSM-5* diagnoses to illustrate the common difficulty of establishing definitive diagnoses for individuals treated in these settings (24).

We then linked these symptom clusters to psychopharmacologic considerations. These considerations were derived from a review of comprehensive psychopharmacologic texts (2, 3) and the most recent professional society and government guidelines (25–27). Because scant research has been conducted with individuals in low-threshold settings, many of the psychopharmacologic considerations were by necessity derived from research on clinical medication efficacy in conventional outpatient and inpatient psychiatric practices. We explicitly called these statements "considerations," rather than "recommendations," to highlight the fact that little to no research on pragmatic prescribing exists for the use of most medications in low-threshold settings.

Informed consent was not required for this study because no human research subjects were involved in the generation of the literature review or prescribing considerations. Institutional review board approval was not required given the secondary nature of the research included in this analysis.

RESULTS

Practical Prescribing Considerations by Symptom Cluster

For psychiatric providers, perhaps the most challenging aspect of prescribing in low-threshold settings is making a

TABLE 1. Summary of psychopharmacologic considerations for prescribing in "low-threshold" outpatient settings, by psychiatric symptom cluster[a]

Symptom cluster	First-line medication class	Alternative medications
Psychosis	SGA	FGA
Mood	SRI or SNRI (depressive mood symptoms); SGA (manic or mixed mood symptoms)	Mood stabilizer (manic or mixed symptoms)
Anxiety	SRI or SNRI	Hydroxyzine
Trauma	SRI or SNRI	Prazosin
Substance use disorders		
Opioid dependence	Buprenorphine	Injectable naltrexone
Alcohol dependence	Naltrexone	Disulfiram

[a] Low-threshold settings, including street outreach and shelter clinics, are those in which a medication recipient's psychiatric diagnosis may be unknown and collateral information may be unavailable at the time of prescribing. FGA, first-generation antipsychotic; SGA, second-generation antipsychotic; SNRI, serotonin-norepinephrine reuptake inhibitor; SRI, serotonin reuptake inhibitor.

DSM-based psychiatric diagnosis to justify a prescribed medication. Individuals treated in low-threshold settings often do not have access to their psychiatric records. They may not have social support from friends, family, or others who may be able to provide meaningful collateral history. They may not tolerate the lengthy probing assessments required to establish a clear *DSM-5* diagnosis (7). They may not recall or may not feel comfortable disclosing previous manic episodes or past traumas. Duration of symptoms may be difficult to elicit, and substance use may complicate the diagnostic picture. For some individuals, the clinician may be able to obtain past clinical information from public databases for Medicaid recipients, the electronic medical record used in the clinical setting (e.g., the Care Everywhere feature in Epic), summaries of previous clinic or hospital discharges, collateral history from a case manager or social support, or pharmacy records. In practice, however, no widely applicable survey or standard exists for solving such diagnostic dilemmas. Prescribers instead need to rely on their acumen in the moment and use sound clinical judgment to reasonably diagnose and safely treat these individuals.

For individuals with prominent diagnostic uncertainty, a symptom-based (i.e., psychosis, mood, anxiety, trauma, and substance use) diagnostic and treatment approach may therefore be the most reasonable way to weigh the risks and benefits of medication use (Table 1). Medications can be collaboratively chosen to maximize symptom relief while minimizing risks for harm. This approach is particularly suitable when the medication recipient may not be available for a follow-up visit and when obtaining blood work may be impractical. In effect, when initially prescribing to such recipients in low-threshold settings, a provider's best assumption might be that no in-person or laboratory monitoring may be possible.

General Considerations

Across all symptom clusters encountered in low-threshold settings, a few factors should be considered when choosing medications. First, given the significant care barriers experienced by many individuals treated in low-threshold settings, these individuals are at high risk for missing doses and running out of medication. Thus, prescribing medications with withdrawal or discontinuation syndromes, in particular medications with short half-lives, might lead to distress and later reluctance to undergo further medication trials (22). Simple medication regimens (e.g., one medication with a moderate-to-long half-life and dosed once per day) might aid in adherence. Second, gastrointestinal adverse effects can be particularly troubling for persons without access to restrooms. Slower titration or avoidance of medications with potent gastrointestinal effects should be considered (22). Withdrawal symptoms, distressing gastrointestinal effects, or any other adverse medication-related effect could influence an individual's willingness to follow up for further treatment. Third, medications requiring refrigeration or secure storage should not be prescribed to persons who do not have access to these amenities (28). Finally, factors such as limited financial means and lack of access to personal transportation can be barriers to acquiring medications from pharmacies. Ideally, low-threshold practitioners might develop partnerships with pharmacies that deliver medications to the clinic or to nonresidential settings. Treatment team members, including peers, outreach workers, community health workers, or navigators, could help by accompanying clients to the pharmacy or even by picking up medications from the pharmacy and delivering them to clients. If nothing else, providers should attempt to use nearby pharmacies that clients could reasonably access by foot or public transportation.

Psychotic Symptoms

A first symptom cluster to consider is psychosis, which may include symptoms such as hallucinations, delusions, and disorganized thinking and behavior. Second-generation antipsychotics (SGAs) are a reasonable medication class to use in treating individuals with psychosis in low-threshold settings. SGAs do not require routine or extensive laboratory monitoring when they are prescribed for short courses, although longer-term SGA use is associated with weight gain and risk for developing metabolic syndrome and type 2 diabetes mellitus (29). SGAs are preferred over first-generation antipsychotics (FGAs) because SGAs have a lower risk for inducing debilitating extrapyramidal symptoms that can impair movement (2). Because SGAs do not differ significantly from one another in efficacy for managing psychotic symptoms, patient choice as well as past responses, adverse effect profile, and cost should be paramount drivers for selecting an SGA (30). One adverse effect that warrants special consideration for individuals who sleep in unsafe spaces (such as shelters, outdoors, and others) is sedation. Individuals who are sedated may be unable to defend themselves from unpredictable interpersonal violence (7, 22, 28).

For individuals who have a known treatment history, have been seen several times at a given clinical site, and are amenable to injection medications, long-acting injectable antipsychotics (LAIs) may be appropriate for psychosis management. Expert consensus recommends a brief oral trial (between 4 and 14 days) of the antipsychotic before administering an LAI (31). In a large, prospective trial using a national database, LAIs reduced rehospitalization rates by 20%–30% relative to oral antipsychotic medications (32). Numerous other studies have shown benefits of SGA LAIs relative to oral agents in relapse prevention and rehospitalization rate reduction (33–35). Several studies have reported that LAIs can be particularly helpful for medication adherence for persons who are not housed (36–38).

Mood Symptoms

A second symptom cluster to consider is mood-related symptoms, which include mania, hypomania, depression, and mixed mood symptoms.

Mania and hypomania. Given the risk for injury or death during manic episodes, individuals experiencing acute mania meeting *DSM-5* criteria should almost always be referred to emergency psychiatric services rather than treated in a low-threshold setting. For individuals with a compelling history of mania or hypomania who are not in the midst of an acute episode but present to a low-threshold setting for medication support, SGAs have an advantage over lithium and most anticonvulsants in that they are not dosed based on blood level and thus do not require immediate or long-term laboratory follow-up.

SGAs are preferred for mood stabilization in low-threshold settings. However, if these medications prove inadequate, valproic acid could be carefully considered as an alternative in certain cases. That said, should valproic acid be prescribed, valproic acid levels and liver function should be monitored to ensure that the individual is not experiencing toxicity (39). Any person with the physiological possibility of pregnancy should receive a birth control test before starting valproic acid, and some form of birth control should be offered if valproic acid is prescribed. Lithium should likely be avoided in low-threshold settings. Lithium requires laboratory monitoring, has a narrow therapeutic index, and lithium toxicity can be lethal. Factors such as dehydration can quickly lead to high lithium blood levels, which can damage critical organ systems, such as the kidneys (40).

Depression. For an individual who presents with depressed mood, it is essential to first screen for previous manic, hypomanic, or mixed mood symptoms that might suggest an underlying bipolar diathesis. If concern for a bipolar diathesis is low, an antidepressant is a logical first-line treatment for depressive symptoms. A serotonin reuptake inhibitor (SRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) would be an appropriate first choice (41). SRIs and SNRIs have relatively moderate adverse effect profiles and low risk of overdose death and do not require strict laboratory monitoring. These characteristics make them ideal medication classes to prescribe in low-threshold settings (41–43).

Bupropion may be a safe and effective antidepressant option for many individuals treated in low-threshold settings. Before prescribing bupropion, it is important to screen carefully for seizure history as well as alcohol and benzodiazepine use, which can increase the risk for seizures in withdrawal settings (44).

Mirtazapine and trazodone can be effective adjuncts for treatment of patients with depressive symptoms, particularly for insomnia. However, it is again worth considering dangers associated with the sedating effects of these medications, particularly for individuals who sleep in unsafe settings, who are at risk for unpredictable violence (7, 22, 28).

SRIs and SNRIs are preferred to tricyclic antidepressants because they have greater efficacy, lower discontinuation rates, and lower risk of overdose death (45, 46). Monoamine oxidase inhibitors (MAOIs) are best avoided in low-threshold settings because they increase the risk for life-threatening hypertensive crisis if rigid dietary restrictions are not followed (47). Risks such as serotonin syndrome are also inherent in initiating MAOIs in proximity to other recent and possibly unmonitored antidepressant trials (48). Finally, although the selegiline patch is a good antidepressant option for persons who have not responded to other medication classes or who are averse to oral medications, its high cost makes it likely impractical to use in low-threshold settings (49).

Mixed mood symptoms. If an individual cannot provide a clear treatment history and past records are not available, a conservative approach to managing depression when bipolar disorder has not been ruled out might be to prescribe an SGA for its mood-stabilizing properties. Quetiapine, for example, has been shown to be an effective monotherapy for treating patients with major depressive disorder or bipolar depression (50, 51). It is worth noting, however, that quetiapine, like antidepressants, has a risk for precipitating phase change to a mixed state, hypomania, or mania (51, 52). This risk decreases with higher quetiapine doses, and at 600 mg per day, the risk is equivalent to the frequency of phase change with lithium (51). Again, because of this medication's sedating effects, special consideration is warranted when prescribing quetiapine to individuals who sleep in unsafe settings.

Anxiety Symptoms

Anxiety is a third symptom cluster to consider among clients in low-threshold settings. According to professional treatment guidelines, the first-line treatment for generalized anxiety disorder is an SRI or SNRI (25). Even if a formal anxiety disorder diagnosis cannot be made, given the relative safety of SRI and SNRI medications, individuals who present with primary anxiety symptoms in the absence of acute substance use or evidence of a bipolar diathesis could benefit from these medications.

Additionally, given their rapid action and U.S. Food and Drug Administration approval for a variety of anxiety presentations, benzodiazepines could be considered in the treatment of unspecified anxiety. However, as we discuss below, the risks of prescribing benzodiazepines in low-threshold settings might outweigh potential benefits.

A final class of medications that might be considered for managing anxiety is antihistamines, such as hydroxyzine. These are non–dependence-forming agents that can be effective for treating individuals with acute anxiety (53). Again, providers should use caution when prescribing these sedating medications to individuals who sleep in potentially unsafe places.

Trauma-Related Symptoms

A fourth, and common, symptom cluster seen in low-threshold settings is trauma-related symptoms. Recent evidence raises questions about whether psychotherapy, the previous treatment standard, is more effective than medication in the treatment of individuals diagnosed as having posttraumatic stress disorder (PTSD) (54). In low-threshold settings, upfront medication prescription may be appropriate during phases of engagement and shared decision making regarding possible short- or long-term therapy initiation. According to professional treatment guidelines, first-line medication classes for PTSD are SRIs or venlafaxine (an SNRI) (26). As discussed above, SRIs and SNRIs have low risk profiles and do not require routine laboratory monitoring, making them suitable for use in low-threshold settings. Some evidence suggests that prazosin can effectively manage PTSD-associated nightmares. However, in a recent trial of combat veterans, prazosin did not alleviate distressing dreams or improve sleep quality (55). Current evidence recommends avoiding benzodiazepines in acute-trauma settings, given their lack of efficacy (56).

Substance Use Disorders

A final symptom cluster that is common in low-threshold settings involves illicit substance use.

Opioid use disorder. Three core medications are used in the maintenance management of opioid use disorder: buprenorphine, methadone, and naltrexone (57). Buprenorphine is an effective, relatively safe, and easy-to-initiate outpatient treatment for opioid use disorder. Persons with this disorder who take buprenorphine are more likely than those who do not take it to remain in treatment (58). There is evidence to support the use of buprenorphine in low-threshold settings (59, 60). As a vital arm of the opioid overdose crisis, public health services are developing and implementing programs to treat individuals with opioid use disorder with buprenorphine in low-threshold settings. One example is the street overdose response team created by San Francisco's Department of Public Health. This team works in conjunction with the street medicine team of the Department of Public Health to address the opioid crisis in San Francisco by delivering buprenorphine to high-risk housing sites and other locations (61). Of note, during the COVID-19 pandemic, telemedicine-enabled models have made buprenorphine even more accessible (62).

Under federal law, methadone for the treatment of persons with opioid use disorder can be dispensed only by treatment programs certified by the Substance Abuse and Mental Health Services Administration (27). Oral naltrexone is challenging to use for opioid use disorder because its effectiveness is dictated by adherence (57). Without regular monitoring clinic visits and additional supports, such as psychosocial substance use treatment, naltrexone is often ineffective in its oral form. Extended-release naltrexone—an injectable medication—may be the most effective way to use naltrexone in low-threshold settings. However, if individuals are physiologically dependent on opioids at the time of naltrexone injection, they will enter excruciating precipitated withdrawal. Given the potential difficulty in ensuring that individuals treated in low-threshold settings are not opioid dependent, dosing this medication could be precarious (57).

For all persons at risk for opioid overdose, naloxone—an opioid antagonist—should be prescribed for use in the event of an opioid overdose (63). Evidence suggests that intranasal naloxone is the most effective delivery method for use by untrained community members (64, 65).

Alcohol use disorder. Three medications have extensive evidence bases for the maintenance treatment of alcohol use disorder: naltrexone, disulfiram, and acamprosate (66). Naltrexone is a reasonable first-line medication for routine maintenance management of alcohol use disorder given that it is generally safe and well tolerated. It can reduce heavy drinking even if an individual continues to drink while taking the medication (66). If the individual tolerates naltrexone and wishes to further curb alcohol use, the provider might offer assistance in accessing tailored substance use treatment.

Both disulfiram and acamprosate work to maintain abstinence from alcohol (66). In a singular low-threshold-setting interview, assessing for abstinence preparedness might be challenging. Even if an individual is clearly dedicated to pursuing abstinence, it may be preferable to refer the individual to a detoxification or rehabilitation program rather than to prescribe these medications, particularly if it is unclear whether the individual has experienced life-threatening alcohol withdrawal in the past.

Benzodiazepine use disorder. No well-established, evidence-based treatment is available for benzodiazepine use disorder. To avoid life-threatening withdrawal, some research recommends cross-titrating to a long-acting benzodiazepine (67). This approach would require prescribing a controlled substance, which might generally be avoided in low-threshold settings, as discussed below.

Stimulant use disorder. To date, no medications have produced consistent clinical trial evidence for the management of stimulant use disorders (68). In low-threshold settings, it would be reasonable to address co-occurring substance use disorders or to aid persons with stimulant use disorders in accessing contingency management services. Of note, there is evidence for the use of antipsychotic medications to treat individuals with stimulant-induced psychosis (69, 70).

DISCUSSION

Many open questions remain about how to prescribe psychiatric medications in low-threshold settings. In the following discussion, we aim to identify some foreseeable dilemmas around prescription duration, controlled substances, other high-risk medications, novel strategies to inform prescribing practices, and value-concordant care and research.

Prescription Duration

It is important to consider whether a given prescription dosage could increase the risk of death or serious injury in the setting of overdose. Various strategies, such as bubble-packing the medication, prescribing 7 days of the medication with refills, or, if legal and feasible, holding the prescription at the low-threshold site and dispensing a week's worth of medication at a time, could reduce this risk for self-harm.

When considering how many pills or refills of a medication to dispense, prescribers must balance a range of factors, including promoting longitudinal treatment engagement, managing acute or subacute symptoms, or continuing medications an individual is currently taking. Each goal might dictate a unique time line for prescribing initial and subsequent medications. Limiting medication fills to 30 days with no refills could encourage treatment reengagement. Follow-up visits could be essential for monitoring medication responses and offering additional resources to patients. During these visits, providers could also address adverse effects that could interfere with treatment. Further considerations that may influence duration of prescriptions include, but are not limited to, availability of prescription drug–monitoring program records for cross-referencing, availability of collateral for verification of previous medication regimens, duration of use and tolerability of the current medication, medical risk of a given prescription to a specific recipient, risk for medication misuse or diversion, and cost of the medication. Ultimately, if a patient is well known to a low-threshold service provider, the prescriber may determine that refills can be reasonably and safely dispensed to the patient. Besides these timing considerations, it is important to concretely consider where patients might receive their next medication prescription, including but not limited to the current low-threshold setting, another low-threshold setting, or an established outpatient clinic to which they have been newly connected.

Although it may be tempting to assume that the prescriptions provided in low-threshold settings will serve as a bridge to more enduring, focused, and stable outpatient psychiatric care, significant risks arise if the medication recipient does not present for follow-up care and if medications become a "bridge to nowhere." The greatest benefit that prescribers at low-threshold settings may provide in such instances is to be welcoming and empathic, establish a therapeutic and collaborative relationship, prescribe safe and tolerable medications for symptom relief, encourage repeat visits, and work to connect the individual to additional resources. The practitioner's goal might remain connecting the patient to long-term outpatient care even when larger social factors might nullify this possibility in practice.

Controlled Substances

Deciding whether to prescribe controlled substances in low-threshold settings can be a challenging dilemma for treatment providers. Benzodiazepines are helpful in the acute treatment of individuals with anxiety, and stimulants can manage functionally impairing attentional conditions. However, with the exception of buprenorphine, which has an evidence base for use in low-threshold settings (59, 60, 62, 71), we feel that prescription of a controlled medication requires an established treatment relationship that is grounded in mutual trust. This relationship helps ensure that these medications, for which the risks for misuse are severe, are being taken safely. The low-threshold setting often does not allow for implementation of such safeguards. Therefore, we caution against routinely prescribing controlled substances other than buprenorphine. However, many individuals served in low-threshold settings could benefit immensely from appropriately and safely prescribed controlled substances. Perhaps the most effective role prescribers could play in such situations is to help these individuals engage with longitudinal care resources in their communities, where these medications can be safely prescribed. It is also worth noting that the COVID-19 pandemic has made access to some of these additional resources more challenging. This reduced access may justify more liberal prescription of take-home supplies of controlled substances for management of substance use disorders, while the crisis persists (72).

Other High-Risk Medications: Lithium, Tricyclic Antidepressants, Clozapine

If a psychiatric medication has a narrow therapeutic index, has high toxicity risk, or requires frequent laboratory monitoring or other regular and ongoing evaluations, it may not be appropriate to prescribe the medication in a low-threshold setting. Such medications include lithium, tricyclic antidepressants, and clozapine. Safely prescribing these medications, even for short courses, is inherently difficult for individuals with an uncertain ability to follow up with treatment, unknown medication adherence, and unknown medical histories. The exception may be for individuals who received one of these medications in a previous setting (e.g., during a recent inpatient admission) and who need a short course of the medication to bridge them to an outpatient visit with a known provider. Still, risks and benefits should be weighed carefully, and collateral history would likely be needed to ensure safe and appropriate medication prescription. For example, a provider in a low-threshold setting might prescribe sufficient clozapine to prevent a patient from missing two consecutive days of the medication, which would necessitate medication retitration, a high-risk scenario. To prescribe clozapine, the provider would need to confirm the medication dose and timing of the last dose, meet federal Clozapine Risk Evaluation and Mitigation Strategy program requirements (including providing an absolute neutrophil count, in accordance with the patient's monitoring frequency), locate a pharmacy to fill the medication, and ensure that the patient is reconnected with their long-term outpatient psychiatric clinic for subsequent clozapine refills.

Novel Strategies to Inform Prescribing Practices in Low-Threshold Settings

To gain a more complete picture of a patient's social situation, with the hope that this broader understanding will lead to safer and more targeted psychiatric medication prescribing, prescribers could consider using the Structural Vulnerability Assessment Tool (73). Derived from social-scientific studies on social determinants of health, this structured interview guide assesses an individual's access to the social, economic, and health resources that may affect their experience with medical and mental health services. In a low-threshold setting, the provider may modify assessment questions to specifically evaluate access to social services, proximity to mental health emergency centers, and presence of a social support system that could assist with medication management.

History of previous medication trials can also be difficult to ascertain in low-threshold settings. Individuals may be distrustful of medications if they have had adverse effects from the medications in the past. Tools such as the Psychiatric Medication History (74) might aid prescribers in gathering information about past medication experiences in a structured and prompt manner. If an individual cannot recall past medications, the provider might also contact one or more pharmacies at which the individual has previously filled prescriptions or reference shared electronic medical records (e.g., Care Everywhere) to obtain this information.

Value-Concordant Care and Research

Finally, and importantly, providing value-concordant care—or care aligned with recipients' treatment goals and preferences—is a major challenge for psychiatric medication prescribing in low-threshold settings. This issue is especially poignant when medication preferences differ between medication recipients and providers. In such situations, to achieve value-concordant care, prescriber attention to the subjective experiences of medication recipients is crucial (75). Individuals may be hesitant or unwilling to take psychiatric medications or to participate in research conducted in these settings. The reasons for this resistance are complex and range from personal experiences to broader cultural influences. Special consideration should be made to the disempowering experiences that many individuals have had with the health care system. Indeed, these experiences have been documented in clinical research, where individuals treated in low-threshold settings have received inappropriate psychotropic medication prescriptions at high rates (23). Such experiences can foster understandable distrust toward medical institutions and their practices (76). For these reasons, it is crucial that informed-consent discussions with patients regarding the risks, benefits, and alternatives to each recommended medication be open and honest. The decision to prescribe medications must not be made lightly. Shared decision making can help providers explore care recipients' values and work toward a consensus for agreeable goals of care (77, 78). These goals could ultimately include more intensive and frequent psychiatric care, including regular engagement in behavioral or other therapies. Notably, prioritization of medication recipients' preferences has been associated with longer and more stable treatment relationships with providers (79).

Limitations

Our analysis had several limitations. First, given the rapid, unsystematic nature of the literature review, it is possible that we missed studies specific to prescribing in low-threshold outpatient psychiatric settings. Still, we identified only two immediately applicable sources after a review of >2,000 abstracts obtained with an extensive list of search terms, indicating an evident dearth of literature on this topic. Second, because little evidence-based work has been published on the prescription of most medications in low-threshold settings, the data on these prescribing practices have, by default, largely been extrapolated from research conducted in more clinical and controlled settings. We used the term "considerations" rather than "recommendations" throughout this review to avoid overstating our conclusions, given the lack of published and applicable research in this area. Finally, although these medication-specific considerations were literature based, a comprehensive review of all clinical psychopharmacologic literature for each medication was beyond the scope of this study. For practice standards, we referenced well-established and comprehensive psychopharmacology texts and up-to-date professional society and government prescribing guidelines. We assume that readers of this review who are prescribers are knowledgeable about the indications, uses, benefits, and common and serious adverse effects of the medications they prescribe. We encourage prescribers to consult comprehensive prescribing resources for complete details on all medications.

CONCLUSIONS

With the growth of crisis services across the United States, including the recent national implementation of the 988 Suicide & Crisis Lifeline, voluntary outpatient psychiatric medication administration in "low-threshold" settings—settings in which a medication recipient's definitive psychiatric diagnosis may be unknown and collateral information may be unavailable at the time of prescribing—is becoming increasingly common. This trend is especially true for persons with diagnoses of serious mental illness who receive psychiatric prescriptions from street-, shelter-, and walk-in–based providers. Here, we conducted a rapid review of prescribing practices and offered detailed practical considerations for providers treating psychosis, mood, anxiety, trauma, and substance use symptom clusters in such settings. To our knowledge, this is the first attempt at an academic review of such practices.

We reemphasize that pragmatic research is desperately needed to translate evidence-based, clinical data on psychiatric medication efficacy to real-world effectiveness. We call on influential psychiatric professional organizations, including the American Psychiatric Association and American Association for Community Psychiatry, to develop and publish guidelines that inform clinical prescribing, shared decision making, and considerations about malpractice and liability in low-threshold settings. Although both research and guideline development will be difficult and complex work, the potential payoffs in improved health and safety from evidence-based standards are enormous. Such investments could also advance the health equity mission on which many low-threshold settings are based: to provide psychopharmacological care to persons without sufficient health care access due to systemic and personal circumstances.

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Appendix E

Failure to Appear: Mental Health Professionals' Role Amidst Pretrial Justice Reform

Leah G. Pope, Ph.D., Tehya Boswell, M.P.H., Adria Zern, M.P.H., Blake Erickson, M.D., M.A.,
Michael T. Compton, M.D., M.P.H.

Pretrial detention reform is keeping people who have been arrested on low-level charges out of jail while they await trial. This reform has implications for people with serious mental illnesses who are overrepresented in the criminal legal system and who can now stay connected to families, employment, community supports, and treatment providers while their cases are processed. However, such reforms may have uniquely negative consequences for those with serious mental illnesses. In this Open Forum, the authors argue that it is critical for mental health professionals to understand what pretrial reform entails and to incorporate planning around clients' criminal legal system involvement into their routine clinical work.

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A decade of criminal justice reform has started to chip away at the roots of racialized mass incarceration in the United States. Amid a reckoning with systemic racism, communities are questioning the corrective benefits of incarceration and are adopting reform strategies, including reducing reliance on police enforcement, reshaping prosecutors' roles, and limiting pretrial jail detention. This should be good news for people with mental illnesses, who are overrepresented in the carceral system, particularly those who are Black or Latinx. It is estimated that 1–2 million people with mental illnesses enter jails annually (1). These individuals are more likely to be detained pretrial, spend longer periods in detention, and face myriad collateral consequences when detained, including limited access to treatment and severed ties with community supports (2). Although pretrial detention reform is a critical part of reform of the criminal legal system nationwide, there are early signs that it may have unintended negative consequences for people with mental illnesses. To minimize or avoid these consequences, we argue that mental health professionals must have a basic understanding of what pretrial reform entails and shift the way they work with some clients who are at risk for failure to appear to court.

PRETRIAL REFORM AND THE MOVE TO A "MANAGERIAL MODEL" OF CRIMINAL LAW

Pretrial reform encompasses a range of strategies to keep people out of jail while they are awaiting trial, including eliminating money bail for most misdemeanors and nonviolent felony cases and implementing court date notification systems. In places like New York State; Philadelphia; Cook County, Illinois; and Harris County, Texas, new laws have eliminated the use of money bail and pretrial detention for most misdemeanors and nonviolent felony cases (3). In New York State, in lieu of detention, anyone charged with a violation, misdemeanor, or class E felony (the least serious class)—aside from some exceptions—now receives a desk appearance ticket (DAT) upon arrest (4). They are then required to appear in court for an arraignment appointment within 30–90 days. Recent analyses suggest that these reforms have significantly reduced pretrial jail populations without jeopardizing public safety (3). For people arrested on low-level misdemeanor offenses (e.g., trespassing or shoplifting), this means being able to stay connected to one's community, employment, and treatment providers while proceeding through the judicial process.

From a critical perspective, Yale lawyer and sociologist Issa Kohler-Hausmann (5) writes about how misdemeanors are now the modal criminal legal system encounter in the United States. Calling on Foucault's (6) notion of "disciplinary power," Kohler-Hausmann argues that lower criminal courts in places like New York City have largely abandoned the "*adjudicative* model" of criminal law—"concerned with deciding guilt and punishment in specific cases"—and instead operate within a "*managerial* model—concerned with managing people through engagement with the criminal justice system over time" (5). This managerial model operates through indirect social control techniques that track defendants' law enforcement contacts, monitor compliance with court schedules and orders, and escalate punishments for subsequent legal encounters or for failing to meet court demands (5).

Implicitly, a managerial approach to justice may involve recognition that low-level offenses are the manifestation of social problems such as poverty and structural racism and are therefore less effectively or legitimately handled by traditional approaches to justice. Yet, the managerial model's primary concern about an individual's "governability and responsibility" has implications for people with mental illnesses (5). After all, in this model, court proceedings can become extended evaluations of a defendant's moral worth. Defendants have opportunities to prove rule compliance but also are given plenty of chances to fail. In New York City's supervised release pretrial program, judges now release defendants to community monitoring in lieu of bail or release on their own recognizance. Judges then evaluate defendants over time on their abilities to satisfactorily follow program requirements. For those with a mental illness, in particular those with functional deficits, this moral "performance" period can be hard to abide by and may end in failure (7).

People released pretrial, whether they have a mental illness or not, must at some point return to court. Thousands fail to attend these court dates each year. Criminal legal systems have historically responded by issuing punitive sanctions, including arrest warrants. Even though less overtly punitive methods such as court date reminders can serve as successful behavioral "nudges" (8), it is reasonable to assume that these measures will not be sufficient to withstand the increased volume of nonattendance associated with pretrial reform. Again in New York City, where policy requires DAT issuance for a substantial subset of charges, higher DAT volume is associated with lower appearance rates (9).

UNINTENDED CONSEQUENCES OF PRETRIAL REFORM FOR PEOPLE WITH MENTAL ILLNESSES

A decreasing jail population is important progress. It should not be surprising, however, that certain trade-offs of keeping people out of jail—sanctions for failure to appear, enhanced supervision, or required programming—have a disproportionately negative impact on people with mental illnesses, particularly those from racial-ethnic minority groups. Multiple studies have reported no-show rates ranging from 10% to >60% for outpatient mental health appointments (10, 11). More research is needed on what drives failure to appear in court for people with mental illnesses. One might intuit that the risk factors for nonappearance are similar to those for missed mental health appointments: long lengths of time between release or discharge and first appointment, substance use, psychosocial impairment, and living in disadvantaged neighborhoods (12). This connection is supported by New York City data indicating that during pretrial interviews, those with mental illnesses scored lower on measures of community ties related to future court appearance (such scores are used to calculate failure-to-appear risk) (13). Parallel mistrust of criminal legal and mental health systems may also contribute (14, 15). The shared root causes of missed mental health appointments and failure to appear in court are important to recognize. Indeed, among individuals with mental illnesses and criminal legal system involvement, those who do not engage in treatment are more likely to be rearrested for small infractions than are those who do engage in treatment (16).

It is clear that much work remains in creating a fair and reasonable criminal legal system. Limiting reliance on pretrial detention and offering people connections to treatment after criminal legal system involvement are positive developments. But it will be critical for communities to monitor how these developments play out over time. Recent examinations of New York City's jail population data are troubling. After an initial statewide reform was passed in April 2019 and enacted in January 2020, the state enacted an amendment in July 2020 that rolled back some of these initial reforms and made more offenses eligible for bail. From April 2019 until the first COVID-19 outbreak in New York City in March 2020, the pretrial jail population declined by 40% (17, 18). However, this pretrial population has steadily increased since April 2020 despite COVID-19–related public health guidance around the increased risks for COVID-19 spread posed by correctional facilities (17, 18). Furthermore, the share of the pretrial population designated as Brad H—an indicator applied to those who receive mental health treatment on at least two occasions when detained—increased from 45% to 52% between March and November 2020 (17). Additional empirical analysis is needed to determine the full impact of these amendments on New York City's decarceration efforts. Still, such trends in one of the country's largest carceral systems are concerning.

WHAT MENTAL HEALTH PROFESSIONALS CAN DO AS STRATEGIC PARTNERS

Mental health professionals can use this moment to become better informed about their local criminal legal system and step up as strategic partners in helping clients meet its mandates—even, and especially, when it is a system that the professionals themselves want to reform. We propose three ways in which professionals might practically integrate pretrial considerations into the clinical encounter.

First, mental health professionals can ask patients questions about criminal legal involvement in everyday practice. This might entail asking about involvement when first meeting a patient and regularly following up about details such as court dates and case outcomes. Supportive psychotherapy, case management, and other strategies can include person-centered approaches to keeping court appointments. Clinicians might track and support court adherence similarly to how they monitor primary care services attendance. Making such conversations part of the routine therapeutic encounter both lessens the stigma of criminal and legal involvement and overtly recognizes the impact that legal cases can have on mental health.

Second, hospitals and clinics can develop systems that allow providers to stay apprised of criminal legal involvement. In New York, anyone can query a public database of court calendars for future appearances, including for DATs. Although such work may be difficult in fast-paced, high-volume, and disposition-focused emergency department settings, clinicians could prioritize queries among individuals with known histories of criminal legal involvement. Further, inpatient units and outpatient clinics could gather information routinely as part of comprehensive care planning. This sort of information gathering could help mental health professionals better partner with patients in reducing the likelihood of pretrial failure and subsequent reprimands such as jail time.

Finally, given the rapid pace of criminal legal system reform, research on the consequences of pretrial reform for people with mental illnesses is urgently needed. We must know whether such well-intentioned reform efforts are paradoxically exacerbating disparities for individuals with mental illnesses. Early research results indicate that pretrial reform in New York may be worsening racial disparities even as it reduces the overall population of people incarcerated in the state (17). Meeting the needs of clients with serious mental illnesses and criminal legal involvement will require a deep commitment to improving the social determinants of health while also building a more just criminal legal system. This can be aided by national pretrial reform efforts. It can be further expedited by informed mental health professionals who are committed to helping clients navigate their local criminal legal system successfully in order to hopefully remain free of further criminal legal involvement.

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Appendix F

I write this preface a year after first completing a draft of the memoir to follow, which details experiences working as a resident physician and treating patients during the first major COVID-19 wave in spring 2020 in New York City. Due to some combination of my own psychological defenses, long work hours, and little free time in my residency schedule, I needed several years to build up the fortitude to write this memoir. By that time, many healthcare workers had already published on their pandemic experiences. I questioned what my perspective might uniquely add and ultimately let it lie fallow. I began to view the memoir as a personal, though ultimately ordinary and expendable, documentation of an extraordinary time. Filmmaker Ken Burns describes an analogous fate for American Civil War photographic negatives. Burns writes that,

> Immediately after the surrender at Appomattox, the appetite for Civil War photographs fell off dramatically. No one seemed to want them anymore. […] Thousands of glass-plate negatives were lost, mislaid, or destroyed. Thousands more were sold to greenhouses around the nation, not for the images but as replacement glass. In the years after Appomattox, the sun slowly burned the image of war from thousands of greenhouse panes (Burns 1991, 1).

Professor Laurie Hart, chair of my PhD dissertation committee, then encouraged me to rejuvenate the memoir in light of novel writings by phenomenologists on the COVID-19 pandemic. When I questioned the relevance of the memoir to a dissertation on psychosis and dependency, Dr. Hart wrote to me, “You should make no apologies/justifications for including [the memoir]. It simply IS part of the dissertation.” Dr. Hart pushed me to consider that, while the memoir might not be immediately topical to the dissertation, it was contextually relevant. After all, I wrote the entirety of the dissertation while treating patients who suffered from pandemic-related mental and physical illness sequelae. As an anthropologist, I would be missing a critical opportunity to interrogate human experience if I waylaid my own account of this tragic time.

Looming Disease and Tragic Death: Help from Phenomenology at the Front Line of a COVID Ground Zero^

The NewYork-Presbyterian Allen hospital, a part of the Columbia University medical system, sits at the farthest northern reaches of Manhattan at the confluence of the Harlem River and Spuyten Duyvil Creek. In spring 2020, the Allen was an epicenter of the first COVID-19 outbreak in New York City. Dr. Lorna Breen, namesake of the 2022 federal Health Care Provider Protection Act, served as medical director of the Allen emergency department at the time of her suicide in April 2020.

Phenomenologist philosopher Anna O'Byrne, writes that,

> For the most part, academics were not among those called to any front line, so we stayed inside and merged with the internet. […] We were told the data and heard the ambulance in the street, but would rarely catch a glimpse of what so much sickness looked like and could not picture so much death (O'Byrne 2022, 105–6).

Unlike many academics, I worked on that front line. Struck by the toll that the virus was taking on New York City and on our hospital system, I kept a handwritten journal during the initial harrowing pandemic months. I transpose selections from that journal here in the hope that the lessons learned and lives lost during those months - a time when all hope was lost for many patients and their medical providers - are not forgotten. I also draw upon novel phenomenological theory to make deductive sense of my experiences of looming disease and tragic death.

Looming Disease. In a co-written introduction to a special issue on the COVID-19 pandemic of *Puncta: Journal of Critical Phenomenology*, anthropologists Jarrett Zigon and C. Jason Throop write that,

> The year 2020 – to put it colloquially (and we often did) – was a shit show, and (as of this writing) 2021 is not shaping up to be much better. Phenomenologically speaking, however, it disclosed significant questions concerning the intertwining of conditions for existence and the singularity of any particular existence. The everyday experience of this disclosure […] could be described as a breakdown that compelled many persons to confront for the first time the conditions of their own and other lives, as well as the many pernicious and precarious aspects of these conditions (Zigon and Throop 2022, 4).

In a solo authored piece in the same issue, Throop then theorizes what he calls "the experience of *looming*" (Throop 2022, 67) associated with the COVID-19 pandemic. He writes that looming is a "distinctively mooded experience" (72), or a form of "affective responsiveness to worldly conditions of possibility" (77), that is "darker, more foreboding" (80) than sadness. Throop views looming as "something certainly distinct from, but perhaps more akin to despair." He writes that,

> When engulfed by despair, I am thus faced with the impossibility of possibility itself. In despair, events, situations, and the world appear as immovable, unchangeable, beyond my reach and control. Like despair, what looms also appears as beyond our control. It is coming, we can feel its approach. In contrast to despair, however, where possibilities are already deemed impossibilities, what looms arises amid a still yet possible – a still yet possible that is attuned to the arrival of a radical reconfiguring or extinguishing of such self-same possibilities. It is the incipient breaking through of what is coming to be. As such, what looms is the pending, but not yet completely actualized collapse of possibilities, as new horizons are reconfigured in the wake of what is coming to be (81).

On March 5, when I began an inpatient rotation at the Allen, I might have described the collective mood in the resident workroom as pre-looming, or a mixture of willful ignorance, compartmentalization, and denial. For the first five days of my rotation, shifts felt relatively normal. I, and my fellow residents, did the routine work of inpatient medicine, including examining, ordering laboratory tests for, and starting and adjusting the medications of hospitalized patients. Each morning, an attending physician led our care team on walking rounds, during which we checked on each patient on our panel. In order to preserve PPE for the few known COVID positive cases, we were instructed by hospital administration to not routinely wear masks.

Within myself, I first noticed a mood more akin to looming when, by March 9, and during these mask-less morning rounds, I learned that more and more COVID-positive patients were presenting to the Allen. I exercised some personal agency - some attempt at control - and asked my residency program director if she might have access to masks. She provided me with a handful of surgical masks donated by a dental office. I shared half of these with a fellow resident.

On March 10, I then watched news broadcasts on the hospital cafeteria TV that announced New York Governor Andrew Cuomo's deployment of the National Guard to New Rochelle, NY, a city located approximately 10 miles from the Allen. The soldiers were tasked with creating a containment area around New Rochelle, where there had been a COVID outbreak. Through the wall behind my computer workstation, I began to hear hospital administrators yelling and arguing. These same administrators would then walk through the resident workroom on their way to the hospital floor. At times, they stopped to tell us that the situation with COVID at the Allen was managed.

By March 13, we were shown videos for how to appropriately don PPE. I then noticed the first of many abrupt changes in hospital workflow. Some hospital consultation services appeared to no longer be seeing patients in-person. In one instance, I admitted a stroke patient whose consultation notes included treatment recommendations based on the history and physical exam obtained by an emergency medicine physician, rather than by the consultant themselves. Those who could fall back from the front line appeared to be doing so.

The looming pandemic was no longer a possibility. It had arrived.

Tragic Death. Judith Butler reflects upon German philosopher Max Scheler's 1915 text "On the Tragic" to illustrate the ways in which,

> The [COVID-19] pandemic makes us reconsider the world as our object of scrutiny, register the world as a cause for alarm, mark the fact that this present version of the world was not anticipated, and register the world as bearing a new kind of opacity rather suddenly and as imposing a new set of limits (Butler 2022, 13).

I recall feeling such alarm when, by March 13, the Allen emergency department was overflowing with ill patients. Those who were mobile enough to walk and sit upright were seated together in a large room adjacent to the emergency department. More acutely ill patients laid on stretchers, which were placed wherever they could fit, including throughout the department's narrow hallways. Some of these patients appeared quite young, possibly even in their 20s or 30s. I remember one patient in particular, a muscular young man who was wearing hospital work scrubs. The scrubs made him appear as if he had just walked down to the emergency department from his day job in the hospital. He was lying quietly on a stretcher in the hallway, eyes closed, and perspiring profusely.

Over the weekend of March 14, any remaining sense of clinical normalcy disappeared. Our emergency department colleagues called the inpatient medicine units with unprecedented requests to admit medically unstable patients, some of whom were near death. One such patient had arrived at the emergency room 20 minutes prior to the admission call. Due to low oxygen levels, she was placed on supplemental oxygen, first by nasal cannula and then by BiPAP (bilevel positive airway pressure). Despite these interventions, her oxygen levels remained low and she would likely need to be intubated in order to survive. I rushed to the emergency room and arrived to find a tragic scene. In an effort to separate patients, and with no open rooms, those who were bed-bound and symptomatic had been placed in what looked like giant, tented plastic bags. These bags featured holes through which hospital staff could administer medications and other interventions. Deceased patients lined the halls, their quiet bodies splayed on stretchers and their cardiac monitors showing flat lines and emanating piercing rings.

I dodged past stretchers and rushing providers to reach the patient, only to arrive and find her already dead. Under unclear circumstances, the patient's family had been granted access to the emergency department despite COVID precautions that excluded visitors. These family members huddled around the stretcher, hugged one another, and cried loudly. They reached through the holes of the plastic covering and touched their loved one. In that moment, I lost some instinct that, in normal times, allowed me to draw on personal and academic experiences to rationalize such life events. Amidst a din of crying, coughing, and gasping for air, I bore witness to the tragic - an uncontrollable mass death. Butler describes such a moment when she writes,

> On the occasion of great loss and destruction of something or someone valuable or, perhaps more precisely, some value that they bear, the tragic emerges, consisting not only in the grief over the one lost, but the shock or bewilderment that the world is such that such an event can happen (Butler 2022, 16).

I returned to the resident workroom and received a call for another admission. This was for a patient with a fever of unknown origin and profuse diarrhea. Emergency department doctors had consulted several remote consultation services about the fever, though none had been able to ascertain the cause. I entered the emergency room again and searched for a mask to wear while examining the patient. I walked past several dead and nearly dead patients. A nurse rushed by and yelled to me that he and his colleagues were doing their best. I asked several staff members for a mask, though was told that they had run out. I located my patient, who was lying on her back, soaked in sweat, and with her long hair matted to her face. I tried to engage her in some conversation to learn more about her illness. She briefly sat up and exasperatingly yelled that she did not know what was happening to her. I vividly remember completing her physical exam. I knew this patient had COVID.

The following day, March 15, I went to the emergency room with my senior internal medicine resident to assess a patient who had been brought in from a nearby nursing home due to respiratory symptoms. We arrived to find the emergency room overflowing even more than before. Intubated patients, some with dislodged breathing tubes, laid on packed stretchers. I went to see the new patient as the senior resident helped reintubate others. I arrived to find my patient unresponsive and with low oxygen levels. The senior resident and I shook the patient awake and asked her if she wished to be intubated. She looked us in the eye and, muffled by the BiPAP mask strapped over her face, said that she wanted to live.

On March 16, a seasoned Intensive Care Unit (ICU) attending physician entered the resident workroom and exclaimed that neither he, nor his colleagues, knew what was going on. A fellow resident returned to the workroom crying after a patient she had been called to admit died in the emergency room from viral cardiac complications. Many of our hospitalized patients became seriously ill, required intubation, and died. Deaths clustered amongst the elderly, though also included the middle-aged and young with co-morbid medical illnesses.

The resident workflow became streamlined. We assessed illness severity by performing physical exams and conducting brief interviews with each patient in the morning. Throughout the day, we then followed vital signs and laboratory tests gathered by dedicated nurses. When patients' oxygen levels dropped, we escalated their supplemental oxygen treatment all the way to intubation.

My rotation at the Allen ended by March 30 and I worked at other emergency rooms and in ICUs throughout the rest of the spring. As time passed and hands-on knowledge amassed, fellow providers developed flow charts and manuals for how to treat this novel disease. The hospital amassed PPE supplies, including lifesaving N95 masks. Though the unexpected continued to happen, the care itself became more routine as protocols were developed and staffing was augmented.

On April 14, I was working an emergency room shift as the junior resident under Dr. Cleavon Gilman, an emergency medicine resident and Iraq War veteran. Dr. Gilman shared a *Men's Health* article - "The COVID-19 War Diaries" - in which he was featured (Paynter n.d.). The piece drew parallels between Dr. Gilman's treatment of COVID patients and his prior military medic career. I had yet to encounter a depiction that so closely captured my own sense of patient and provider experiences over the past harrowing month. I found myself sharing the article with friends and family in an attempt to help them understand the toll that the disease was taking on the hospital system.

On April 26, Dr. Lorna Breen died by suicide. I cried upon hearing the news. I felt overwhelmed in hearing that a fellow physician – the medical director at the Allen emergency department, no less – had taken her life. I read a *New York Times* article published about her death, "Top E.R. Doctor Who Treated Virus Patients Dies by Suicide," and was struck by a quote from her father which read, "She tried to do her job, and it killed her" (Watkins et al. 2020). While I, myself, did not experience suicidal ideation, I could empathize with what Dr. Breen's father said. She had undoubtedly been deeply affected by recent events at the Allen. Dr. Breen's death seemed to be one of the first events in a sea change of acknowledgement about how bad things were inside our vaunted American hospitals, even Ivy League-affiliated and relatively well-resourced places like the Allen. The provider stressors - the uncertainty created by mixed national and local message about COVID's spread, the understaffing, and the lack of PPE and massive disease exposure by frontline staff – had piled up on people like Dr. Breen, who worked to the point of exhaustion. By May 4, per an email sent to residents from the internal medicine residency director, approximately 1,800 patients had died within the NewYork-Presbyterian hospital system.

Concluding Thoughts. The COVID-19 pandemic has been extraordinary in many ways, not the least in its traumatic universality. This coronavirus has, after all, either posed a threat to or killed, each human being on the planet. Phenomenologists Throop and Butler take advantage of this unique moment of universal susceptibility to advance what, in non-pandemic times, is a piecemeal project - generalizing human trauma responses from diverse inciting traumatic events. To this end, and despite not having worked on the front line themselves, I contend that they capture much of the front line lived experience in their respective theorization of looming and the tragic. Through phenomenological theory and narrative, the spring 2020 period at the Allen, which to me seemed senseless at the time, has gained meaning. For me, this meaning was made possible by those like Dr. Breen and others who, standing in front of a wave of death, saved some lives at a time when all seemed lost without the information, PPE, and vaccines needed to ensure personal survival. From confusion, hopelessness, and abandonment came personal, interpersonal, and institutional resource mobilization to counter tragedy.

*Apart from quoted material, I have edited original field notes for cohesiveness and brevity when including them in this dissertation. The University of California, Los Angeles Institutional Review Board approved this research. I completed research project-specific HIPAA training, as required by the Los Angeles County Department of Mental Health, in order to view patient information. I deidentified all client-specific personal information in writing this manuscript.

^ Patient names and other identifying details have been altered to protect patient privacy.

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