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The Ethics and Politics of Involuntary Psychiatric Commitment: Beyond the Total Institution

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The Ethics of Involuntary Psychiatric Commitment:
Beyond the Total Institution

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in Anthropology

by

Abigail Jane Mack

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ABSTRACT OF THE DISSERTATION

The Ethics of Involuntary Psychiatric Commitment:
Beyond the Total Institution

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Abigail Jane Mack

Doctor of Philosophy in Anthropology

University of California, Los Angeles 2021

Professor C. Jason Throop, Co-Chair

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Abstract:

"The Ethics and Politics of Involuntary Psychiatric Commitment: Beyond the Total Institution" examines the lived experience of medical and legal professionals who work at the intersections of the pubic mental health care and justice systems in Los Angeles. The dissertation draws on nineteen months of ethnographic fieldwork that traces the practice of involuntary psychiatric commitment from initial emergency triage to inpatient unit to courthouse where patients may contest the circumstances of their holds. Through this fieldwork, the dissertation demonstrates how public health and justice systems—framed as both "silos" and "revolving doors"—operate as distinct institutions while medical and legal professionals and their patient/clients circulate in and between them. In the midst of these cycles of people and institutional ideologies competing articulations about appropriate care emerge that frame the ethics and politics of enacting involuntary commitment, excluding some people from care and often reproducing structures of systemic racism and poverty. The study mobilizes a critical phenomenological approach to elaborate lived experience of working in and living through systems of inequality particularly as it is disclosed and mediated by language and mood. In the process, it elaborates how everyday encounters within medical and legal institutions may unsettle the political status quo and provide an opening for alternative forms of caring for people in mental health crisis.

The dissertation of Abigail Jane Mack is approved.

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University of California, Los Angeles

2021

DEDICATION

For everyone who is working for more equitable,
accessible, and dignified mental health care
and for my family.

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INTRODUCTION

According to Alice, a night-shift nurse in the Psychiatric Emergency Room (Psych ER) of Los Angeles Public Hospital (LAPH), her saddest case happened about a year before I met her. We sat together for an interview in a dimly lit nurse station, resting after I had shadowed her through a midnight rush of new patients. “More than,” Alice paused, “yeah about a year ago.” She continued, describing for me the moment she arrived to work, how she learned from the day-shift nurses that an adolescent diagnosed with autism disorder had been restrained—belted down to a hard, rubber bed by his wrists, ankles, and waist—for nearly eight hours. Despite the restraint, they told Alice, the patient remained agitated. “Oh, he’s a very dangerous kid,” Alice re-animated her day-shift counterparts. “The kid is really bad,” she mimicked, “the kid is really bad.”

Incredulous, Alice asked to be assigned this “dangerous,” “really bad” kid. She had only been interacting with the patient for a few minutes when his mother called, pleading for his release. After learning more about the particularities of his experience with autism and the many measures that the patient’s mother took to care for him, Alice decided to petition the attending doctor for her patient’s discharge from the hospital. By the time that she convinced the doctor, however, the supervisor of the LA Sheriff’s hospital patrol team had caught wind of her efforts. The sheriff’s deputy asserted that this patient was too dangerous to be released, but Alice remained firm. This was not his decision to make. She told both men, her administrative superiors, that she would stake her license on it. Finally, all agreed to the patient’s release, but not before several members of the Sheriff’s patrol team arrived to stand guard around the hospital entrance. Alice paused in her story and smiled. Contrary to law enforcement’s expectations, the patient walked calmly out of the hospital, hand-in-hand with his mother.

Laughing, Alice leaned forward in her chair and recalled the patient's final word to the patrol team. She held her hand up and lowered her voice, "Bye." It was her proudest moment as a nurse and patient advocate, she said, laughing.

It is tempting—I have been tempted, at least—to listen to Alice's story as a direct experience of her saddest case and proudest moment, a verbatim replay and report of her confrontation with doctor and deputy. From this perspective Alice, a deeply Christian woman who immigrated from Nigeria more than twenty years earlier, has a virtuosic ability to name and negotiate raced, gendered and institutionalized ideologies of ethical caregiving. Yet, as Alice narrates her victory, she also reveals uncertain self-making, meaning-making, and world-making that occurs in the act of narrating itself (Ochs and Capps 2001). Indeed, the process of piecing together events word by word into an unfolding story becomes an opportunity to ponder and question ethical and political orientations to her work. Rather than a flowing theatrical performance, Alice's story emerges slowly, with utterances repeated and re-phrased, utterances cut off, and a range of affect-laden intonation and voice qualities. The emergent telling immerses Alice "in moment-to-moment thinking, feeling and being in the world" (Ochs 2012, 144).

This dissertation views language as an entrée into understanding the conditions which make contemporary practices of involuntary psychiatric commitment possible and as a site in which possibilities of an otherwise are not only elaborated but—even if only for a moment—brought into being. At the same time, it also attends to the ways in which experience may exceed language in atmospheric and mooded ways, elaborating forms of attunement between professional caretakers, their colleagues, and their patients over time (Throop 2014, 2017, 2018, Forthcoming). Medical and psychological anthropologists have long engaged mood in cross-cultural and pathologized ways to understand moral, cultural and medical experience (cf.

Kleinman and Good 1986, Hinton and Good 2009, 2016; Jenkins 2015). In psychiatric practice, mood is hypercognized as a phenomenon to which practitioners may orient and control via diagnosis and intervention (Consider, for instance, the DSM-5 categories of mood disorder). While informed by this literature, I engage mood not only as a pathologized experience in the context of emergency and acute psychiatric practice but also as a medium through which moral and political experience is engaged and negotiated (Throop 2014, Forthcoming; Mack and Throop, In Press). In the process of negotiating involuntary care—its ethics, politics and practicalities—mood operates in distinctive and diffuse ways through vigilant practices oriented to patients that serve to mediate feelings of safety, risk and freedom (See Chapter Three) or in more diffuse ways as a historical and political orientation toward population change (See Chapter Two). In the cases discussed in the dissertation, mood serves as the grounds upon which language praxis and experience emerge and, recursively, language praxis likewise becomes a medium through which a mood or moods becomes concretized.

Today, in California, a person may be treated against their will for up to seventy-two hours without legal recourse, because, by virtue of a mental disorder, they are considered a danger to others, a danger to self, or gravely disabled (unable to access food, clothing or shelter) (California WIC §5150). An involuntary commitment may be extended by fourteen days, then thirty, and eventually a year as a “conservatorship” with various legal oversight if a person continues to represent either a danger (in limited cases) or is considered gravely disabled. After the first three days, a patient who is involuntarily committed may contest their commitment in a probable cause or writ of habeas corpus hearing. In LA, an initial hearing is held for all patients on extended holds in the hospital, while habeas corpus hearings take place in a courthouse that was once downtown and has since been moved. My dissertation fieldwork documented these formalized instances of deliberation and debate in the courtroom and hospital, tracing patient trajectories from initial emergency commitments to ongoing inpatient care to the courthouse where hearings are conducted over the course of nineteen months.

The dissertation, however, focuses on less formalized moments of care and deliberation that operate in everyday practice. Exploring the less explicitly ritualized moments of involuntary care practice—debates about the physical restraint of a patient in the early evening hours, moments when a patient's diagnosis becomes ambiguous, reflections in passing on public mental healthcare systems and policing—I engage a critical phenomenological analytic to 1) understand the operation of structures of inequality and the experiences that form and are formed by such structures as they emerge in and shape an institutional world of psychiatric practice (cf. Butler and Salamon 2017; Guenther 2013; 2020); and 2) unsettle through this understanding the seemingly frozen concepts that undergird involuntary commitment—safety, danger, freedom and care—as existential and political conditions which are fundamental to the negotiation and enactment of treating someone against their will (Mattingly 2019; cf. Desjarlais 1997).

In his essay on the total institution, Erving Goffman (1961) describes such a space as one in which individuals and their daily lives are subject to the same regimented and homogenizing treatment and control as a group of inmates or patients. Importantly, every institution provides "something of a world" for its members (ibid, 4). Goffman concedes that multiple worlds may be in operation in an institution, noting, for instance, that any totalizing effects of the institution would be very different for staff members who may come and go as they please from the institutional world experienced by patients. From a phenomenological perspective, I understand a "world" as the "horizon of horizons," shaping in certain yet flexible ways the conditions of possibility, meaning and understanding for a given person (Guenther 2013, 32). At the same time, no world belongs completely to a single individual but is shaped relationally and variably by others with whom we share the world and certain "quasi-transcendental" cultural and social structures and systems which operate in and between such worlds (Guenther 2013, 2020; cf. Zigon 2018).

Grounded in the context of involuntary psychiatric care in a public, safety-net hospital where clinicians and law enforcement interact intimately in the implementation of such care, this study seeks to elaborate aspects of social structures of inequality and political, ethical and institutional ideologies as they present themselves in, shape and are shaped by everyday performances of involuntary care. From a phenomenological perspective, such structures are non-totalizing, forming instead a relatively but not entirely fixed set of possibilities for doing, being and acting in an institutional world, elaborated through and mediated by political, ethical and emotional experience that may exceed any rigid institutional ideological form (cf. Butler and Salamon 2017; Zigon 2018). In engaging systems and institutions as determined and determining and yet non-totalizing and non-totalizable, I seek to elaborate not only how such structures may be reproduced even unintentionally but also the way in which such systems work recursively over time to elaborate a particular world and social reality. Questions about who is deserving of care, what such care accomplishes and when it is appropriate become critical to fathoming how the lifeworld of a professional caregiver informs the institutional world as a patient may experience it. Also, understanding how people experience and make decisions in such a world provides insight into the ways this world may be made and remade in the process of a particular activity or set of decisions and the ways horizons of possibility may be elaborated and, critically, re-elaborated through such understanding.

To demonstrate my approach to theory and practice, I attend in this introductory essay to Alice's story as it unfolded between us. I center analysis on the progression of the question "What are we doing?," which Alice posed again and again to the attending doctor with whom she worked and, apparently, herself. Considering the grammatical tense, repetition and perspectival function of this question over the course of the study, I analyze how Alice's reanimation of her confrontation with doctor and deputy draws a long-past ethical dilemma forward for renewed negotiation and, in the process, opens again a series of new possibilities for being and working with people in states of mental crisis. Such an analysis depends upon a critical understanding of the institutional world in which these questions are asked and the way such a world has been informed by social structures that may have long preceded any given iteration of the world as people encounter it. Turning Alice's question on myself, I conclude this introduction with a consideration of what I have done and am doing in ethnographic work and this dissertation. I end with a reflection on the potential for critical phenomenologists to engage meaningfully with and contribute to efforts of transformative justice.

This dissertation is based on fourteen months of ethnographic fieldwork conducted from 2016-2017 in the psychiatric emergency room and inpatient units of LAPH, one of LA county's three safety-net care facilities. Research in LAPH (IRB# 15-000687 and #810686) was supplemented by five months of fieldwork in Los Angeles County Superior Court Department 95, the LA mental health court. Over this time, I mobilized a range of ethnographic methods including: focal follows of medical and legal professionals over the course of their work shifts in the hospital and courtrooms, in-depth person-centered interviews with professionals and patients, surveying and scan sampling of the three primary fieldwork spaces (ER, inpatient unit and courtroom), social and institutional mapping exercises with professionals to capture their visualizations of the interfaces between legal and medical institutions (See Chapter One), and the development of two archives: 1) historical documents covering the writing and establishment of contemporary involuntary commitment laws and 2) institutional and bureaucratic form work that mediates involuntary commitment laws today. In my analysis of the fifty recorded interviews and approximately 1,200 pages of fieldnotes collected during this period, I deploy linguistic anthropological techniques to explore the operation of language practices in involuntary commitment procedures and to elaborate how language in situ may elaborate various mooded orientations to such work. I will deploy those methods below (a list of transcription conventions is included in an appendix of this dissertation)

Los Angeles Public Hospital and Assessments of Danger

The psychiatric emergency and inpatient units at LAPH were built with the expectation of crisis. Located centrally in each unit are nurse stations with plexiglass windows that overlook patient common areas. Aiding in the surveillance effort are strategically placed cameras and dome mirrors through the units. Inside the stations, computers line the windows so that nurses may keep eyes on their patient at all times, even while they are typing their patient notes or documenting procedures. The units are sparse. All precautions are taken to keep small items off the unit that may be used to hurt oneself or others. There are payphones in the units, but their cords have been shortened. Most of the furniture is made of hard rubber and weighted so that it cannot be thrown or otherwise used to injure another. The windows on the units are sealed. As a fire precaution, however, the exit door in the emergency room (at least) is unlocked and weighted, making it difficult to open but not impossible. In the inpatient unit, patients sleep four to a room, each with their own bed and bedside table. The ER is far more open, patients may close curtains around their bed, but most often they are left open so that staff can maintain a careful eye on everyone.

Except for the very rare case, all patients in the Psychiatric Emergency Room and inpatient unit are kept there on involuntary psychiatric holds. For patients in extreme crisis, medical staff may intervene by administering an injectable medication of sedatives and may also use physical restraints as needed with or without patient consent. These practices are upheld by various laws on mental healthcare that have been written and reformed since the passage of the Lanterman-Petris-Short Act in 1967, which served as the legal mechanism through which much of the deinstitutionalization of state hospitals in California occurred (See: Chapter One). The first of these laws to be listed in the Welfare and Institutions Code is the 5150, the now colloquial term for 72-hour hold. For the most part, Alice told me, she agreed with the application of the law and use of the 5150 as it occurred in the psychiatric emergency room. It was necessary for patients whose illness often prevented them from recognizing the need for care.

Alongside this law, exists a paradigm of the dangerous or gravely disabled patient (a kind of danger, one doctor explained), the patient with whom it is appropriate to administer involuntary care and the interventions that come with it. The majority of the patient population in the psychiatric units at LAPH consists of adults (over 18). The most common diagnoses are schizophrenia, schizoaffective disorder, bipolar disorder and “psychosis not otherwise specified,” often these are co-morbid with other disorders like substance abuse disorder, depression and anxiety, and in the less frequent but not unheard-of case, Autism Spectrum Disorder.

Alice’s patient was a fifteen-year-old boy who was nearly six feet tall and looked to Alice like a football player—a physical suggestion of his potential for danger, which the other nurses noted directly. The patient had been agitated, too. He continued to “move” and “yell” even after initially eight and eventually twelve hours of restraint. Yet, despite these various suggestions of his potential dangerousness, despite the fact that the treatment of the patient reflected institutional standards of care for crisis intervention, his presence in the Psych ER represented a serious breach for Alice. This becomes apparent in Alice’s account of her first confrontation with the doctor:

Alice:

1. “I said, ‘Doctor, I’m begging you.”
2. I said, ‘This boy’s been in restraints now for over 12 hours.
3. ‘What are we doing?’
4. I said, ‘What are we doing?’
5. I’m going to come here now.
6. I just got to work.
7. I’m going to put him in another 8 hours restraints here?
8. I’m not going to do it.”

To ask a question is to risk opening previously settled matters, to subject self and other to uncertainty. In the first iteration of the question “What are we doing?” (line 3), Alice opens the standard, institutionalized manner of treating an aggressive patient for question. Aided by the present progressive “are we doing?” with an extra verbal emphasis on “doing,” this question marks the ongoing treatment of the patient as an event worthy of critique. The immediate repetition of the question builds and—through changes in pitch and intonation—elaborates on this first iteration. Raising the pitch of her voice while lowering her volume, Alice indicates a sense of exasperation, urgency and also a departure from the situation.

The two questions together function rhetorically. While this second “What are we doing” continues to imply a sense of openness to the doctor’s opinion, the “situated force of the utterance seriously undermines the veracity of any answer other than the one implied by the speaker” (Jasinski 2001, 494). If the correct answer to Alice’s question remained in any doubt, Alice fixes that. She casts forward into an intentional future via the present progressive (auxiliary verb) —"I'm going to come here now" (line 5)—to elaborate the *irrealis*, the not yet realized, an unacceptable potential consequence of the event marked by her question. In the process, Alice departs from the inclusive "we" in "What are we doing" to a singular "I" in "I'm not going to <u>do it."</u> (line 8).

The repetition of the question not only marks the event of a child's restraint as open for ethical reconsideration but, mediated by verbally realized moods of urgency and disbelief, imply a kind of moral force—an imperative that has, in Alice's view, not yet been met. Like a Greek chorus, the repetition of the question operates recursively—each question recasting the one before it—steadily honing Alice's critique of the patient's care. A few minutes later in her narrative, Alice questions the doctor again:

Alice:
9. "What are we doing with an autistic child that we don't even know-
10. I said, 'it's more of a liability for us to keep this kid in restraints
11. Than sending him home
12. To someone who can <u>care</u> for him.'

Now back in alignment with the doctor and the institution ("we" line 9), Alice refines her question: "What are we doing with an autistic child that we don't even know." She cuts off the question. (I believe she was going to say "that we don't even know how to care for"). She then redirects attention toward potential legal consequences (line 10), before implying that the hospital staff cannot properly care for this particular patient (line 12). Here "What are we doing?" is refined to address the 5150 patient paradigm, the rules about how and for whom involuntary care operates and the articulations of danger that accompany such rules. Contrary to her colleagues' assessments, the patient is *not* a "dangerous kid," but an "autistic child" (line 9). In this case, both the diagnosis and the age of the patient mark the patient as unique, an outlier, not an appropriate subject of involuntary care. To further position the patient beyond the Psych

ER's purview, she places "what are we doing?" within the context of legal concern and liability, perspectives that dictate much of the work that occurs in the psychiatric units at LAPH as doctors are regularly held accountable for their decisions in probable cause and writ of habeas corpus hearings.

The first iterations of the question repeated immediately, one after the other, build their moral force through an embodied and mooded disposition—a tone and pitch of voice that indicates the rhetorical quality of the question, its moral urgency, and may provoke a consideration of an otherwise (where the child has not been placed in restraints or could be viewed as innocent rather than dangerous). In the second round of questioning, Alice taps into another aspect of her assumed shared social context—the legal/institutional ideologies that undergird the Psych ER's operations. If one accepts the implications of Alice's refined "What are we doing?" and the patient's case is in fact a breach of institutional paradigm, then Alice is right. The hospital is liable. Critically, Alice continues her alignment with the doctor here. It is a liability for "us." Mirroring the vernacular register of her colleagues—as she mimicked them earlier—she shifts to cast the patient as a "kid" (line 10), suggesting a kind of attitudinal alignment. This also serves to position the patient's family as constitutionally different from the hospital, from the institutional "us," as "someone who can care for" the patient. Here, the asymmetrical relationality often at the core of moral experience (Zigon and Throop 2014)—between Alice and the Doctor, between Alice and the patient, between Alice and the institution—becomes apparent and critical.

As Alice makes sense of her own decisions as nurse and patient advocate, she does so in the context of an institutional world framed by hierarchies of knowledge and experience. The pressure to maintain the hold—the pressure which Alice must mitigate—is further heightened by the moral weight of protecting the public from “danger” represented by the patient. On the one hand, Alice’s “What are we doing?” is a powerful form of resistance to institutional norms of bureaucratic hierarchy. In asking such a question, Alice is adjudicating the law that undergirds the Psych ER’s practice of involuntary commitment. She is outlining and refining the parameters and scope of the institution’s actions upon patients. Yet, the tools available for Alice are somewhat limited, confined by the legal language and priorities of the institution itself. In opening the possibility of an otherwise way of seeing her patient as neither a danger nor an appropriate subject of psychiatric emergency intervention, she also, implicitly, describes a patient who *is* appropriate for such care. Thus, while she resists, she is also maintaining a justification for the institution of involuntary commitment and securing her position as a moral agent of the institution.

Yet, there are other existential possibilities present for Alice; the story that she tells is ongoing, unfinished. The open possibilities which remain become visible when one reconsiders her narrative performance as an experience that draws her past engagement with the patient, doctor, and law enforcement forward into the here-and-now for renewed negotiation and moral evaluation. As a moral experience not constrained to the singular event (i.e. encountering a problem with the patient, negotiating solutions, ensuring the patient is discharged) but, rather, one which can be reengaged and re-experienced, albeit in a different time, context and with different stakes; the telling of this narrative affords the possibility for her to realize a different way of being and acting as a psychiatric nurse at LAPH. These possibilities are emergent in the narrative itself. As Alice reaches the end of her tale and I am at this point steadily “mm-hmm-ing” along with her conclusions, the moral experience that emerges in the course of Alice’s narrating occurs not only through her engagement with the subjects of her story or her engagement with the institution but also her engagement with me as empathic recipient of the narrative and with herself as its primary teller.

When Alice finished her story, she commented that it was fortunate and logical that the doctor agreed to release the patient:

> **Abby:** What do you—Why do you think that doctor did it?
>
> **Alice:** Maybe he was able to reason with me, you know, because I told him the legal aspect of it: "Why are-are we putting someone here in restraints? Anything can happen to this kid in restraints."
>
> **Abby:** mm-hmm
>
> **Alice:** You know, and we're not able to care for him?
>
> **Abby:** mm-hmm
>
> **Alice:** "He cannot speak or understand what we are saying. And then there's, there's-there's the, there's the evidence that-uh-he's never been out of home? And he's autistic. So, what are we doing with him, for real?'
> [
> **Abby:** yeah

In this final reflection, Alice moves to position the patient as vulnerable, "he cannot speak or understand;" innocent: "he's never been out of home?" and an inappropriate subject of involuntary care: "he's autistic." Thoroughly severing him from his association with danger, his release now seems like the obvious, only choice. Positioned as it is in Alice's metapragmatic recollection of each rhetorical strategy that she deployed during her petition to the doctor, this final morally challenging question: "So what are we doing with him, for real?" could be considered as simply the final rhetorical strategy in the list. Yet, having "mm-hmm-ed" my way along with Alice in this final reflection, I join her in her final question: "yeah." And, so, from another perspective, this question can be seen as an enduring dilemma for Alice that has become amplified again for the moment in my interview with her. Alice is a masterful storyteller.

Throughout the narrative she engages me with suspense; she draws me into her sense of urgency about the patient's case; and she brings forward the perplexing questions that shaped this case for renewed consideration. The use of the present progressive "What *are* we *doing*?," not "What *were* we *doing*?" keeps the historical moment open for present consciousness. The shock of the event, the moral force of the question remains even—or especially—as the question stays unanswered.

In the moments after her story has finished, Alice shifts the conversation to consider her role as a patient advocate: "I don't know, sometimes is it that we lack a lot of us lack that-uh-because we should always realize that we are patient advocate." She continued a little later: "A lot of nurses, they don't take that initiative. They don't know that they are patient advocate. You can speak up for patient. You know. You could." She continued, "nurses need to be not afraid to speak up for their patients." In this declaration, Alice recasts her work with the patient as one of ongoing labor as a patient advocate, one which she makes possible in speaking up. One, which she recognized may not always be realized by others, but one which—in asking "What are we doing?" Alice has now incorporated into her way of being as a nurse.

What am I doing?: Ethnographic Methods, Transformative Justice, and Critical Phenomenology as Kindred Practices

Eight months after I completed fieldwork in Los Angeles Public Hospital, my world was changed profoundly. On April 11, 2018, my sister, Anna, died by suicide. Anna had struggled for years with addiction and a mental disorder that was never definitively diagnosed as she cycled through jail and emergency clinics. Not long after Anna had her first, serious mental health crisis, my younger brother, Sam, began showing similar symptoms of both mental disorder and addiction. Sam, likewise, cycled through carceral and emergency care, receiving various diagnoses along the way. In those early years of their illnesses, I found myself frustrated and troubled by my desire to somehow contain Sam and Anna in order to keep them safe from the prison and jails that had repeatedly traumatized them and exacerbated their distress. Yet, in times of crisis, there seemed to be very few formal emergency psychiatric treatment options available in our hometown of Indianapolis, or any clear linkages between emergency services and consistent outpatient care. I had been drawn to Los Angeles to study what—from my perspective in the Midwest—appeared to be a far more robust and accessible mental healthcare system and, yet, still a system that relied heavily on the incarceration to provide mental health care for many (See: Chapter One). My love for my sister and my brother inspired me to look more closely at the intersections of criminal justice and mental health care in Los Angeles as a way to shine light on the operation of mental health care in other parts of the country.

Anna and Sam inspired my approach to my research at every level. When designing the study, I was particularly concerned by the people who were "in charge," those bureaucrats—doctors, lawyers, judges—who oversaw the administration of clinical and courtroom sites and could determine the fate for many patients of their care. Entering the realm of emergency psychiatric practice from an academic perspective required extensive research design and ethical reviews of said design. I obtained a certificate of confidentiality from the National Institute of Health to protect patients involved in my research and developed a protocol that immediately de-identified patients in fieldnotes and jottings in order to further protect their privacy. Medical and legal professionals are likewise anonymized in all my ethnographic writing, primarily as a means for protecting patient privacy. Finally, I use a composite approach to any identifying information about patients when writing of them in my dissertation. Still, though patient interviews are not presented in this dissertation, I wanted to be sure that analysis was guided by patient experience as well as those experiences described by medical and legal professionals. I made a point to engage patients as ethically and directly as possible, to interview patients when possible about their experiences of care, and to make sure that I stayed accountable to patients, even while I turned my attention most directly to their medical and legal professional caretakers. While I am not entirely convinced that I succeeded in this effort (See: Chapter Three), I hope that I do some justice for those who are most directly affected by the public mental health and criminal justice systems today. I also believe that there is much to be gained by looking closely at the ways in which clinicians, lawyers, and law enforcement think, feel, and act in clinical contexts, in order to understand how systemic harms are reproduced and how they may be dismantled.

As I moved through the shock and grief of Anna's passing, I experienced a fundamental shift in how I viewed and understood the data I had collected. Whereas before, I was attending to the data corpus for the ways in which it might shed light on the fraught act of treating someone against their will; now the fieldnotes, the interviews, every page, every utterance and image—all of it—seem shot through with the risk of loss as clinicians, legal professionals, and patients negotiate danger and care. Even now—the visceral pain of Anna's absence having subsided—I still see, still feel a deep risk of loss threading my work and my writing. Anna's death and her palpable absence reconfigured my relationship to others and sensibilities toward this study. It also moved me to reimagine a world in which Anna not just survived but thrived. For such a world to exist, even in my imagination, I had to consider not only the events that occurred in Anna's life and her death, but also the root causes or conditions of those events. I began to reinvestigate work that I had conducted earlier with abolitionist projects in Indiana and to volunteer with local mental health advocacy groups in Los Angeles. Over time, the closer I felt to this possible world or worlds where Anna is thriving, the more I have been drawn and committed to transformative justice efforts in LA and back in Indiana. And, in that time, I have come to understand critical phenomenology and transformative justice as kindred practices (Mack Forthcoming).

In her work on critical phenomenology, Lisa Guenther (2020) has called for a theoretical engagement and praxis that goes “beyond a description of oppression” (16). Such praxis would involve dismantling systems of oppression and supporting and growing the capacity for open being-in-the-world with others (ibid, cf. Kaba 2020). My path toward such praxis involves embracing and supporting transformative justice efforts wherever they appear. In my case, this includes throwing full-throated support behind former patients and their family members in Los Angeles as they call for the removal of police patrol units from hospitals along with the defunding policing and the reinvestment in community-based care (See for instance Tchekmedyian 2020). It also includes actively cultivating liberating ways of being and seeing the world in ordinary interactions with others.

In the early months of the pandemic in the US, the Barnard Center for Research on Women circulated a video in which popular abolitionist thinkers, writers and activists shared their approaches to understanding and enacting transformative justice. In the video, Stas Schmiedt (they/them), founder of the art-activist collective Spring Up, described transformative justice as “addressing harm, but also understanding why that harm happened, and addressing the underlying dynamics that created conditions of this harm to happen in the first place” (“What is Transformative Justice” 2020). Schmiedt created a circle with their open palms as they spoke the words “addressing harm.” Then, they gestured to a field beneath the circle as they began to speak about conditions. They continued, expanding the circle to include an invisible other with whom harm was being negotiated and then gestured to an area above the circle to describe how a transformative justice approach is not just about the harm that may have occurred between people but also the conditions in a community which made such a harm possible and even normal. Schmiedt's speech is important but their gestures indicate how transformative justice becomes a way of engaging the world, an intentional modification that looks at the conflict at hand in a given moment and the social phenomena below and above which operate as conditions of possibility, conditions which may be transformed. Importantly, these conditions are not only transformed by the critical work of physically dismantling structures of oppression, but also in everyday interactions with others as people seek to hold themselves accountable. This includes investigating one's own emotional response to a situation and the language one may use to navigate those situations.

From a transformative justice perspective, language and mood may become critical sites for intervention at an everyday level. From a critical phenomenological perspective, language and mood may operate not only as sites through which one may recognize the conditions that make structures of oppression possible, but also sites at which one may act in order to engage in the strategic dismantling of such systems. In this dissertation, I mobilize this perspective to attend closely to the way that the institutional world of LAPH functions from day to day and how such a world operates to inform the ways in which people think, feel and act. I look closely at the ways in which language expressed and interpreted reveals a sense of the world as it is and as it might be otherwise. Before each chapter, I include a fieldnote section which elaborates elements of the chapter that follows as they emerged in everyday interactions in the hospital.

In Chapter One, I attend closely to the institutional perspective adopted by many of the interlocutors whom I encountered in the course of this ethnographic study when tasked with considering the world beyond LAPH. When describing what may happen to a patient once they leave the hospital, for instance, these interlocutors relied heavily on notions of cycling and siloed forms of knowledge encapsulated in the all-too-common medical and legal metaphor, the "revolving door." Using the "revolving door" as a guidepost, I turn my attention to the history of involuntary commitment in California to understand how such cyclical ways of seeing and understanding the public mental health care system became possible. In the process, I position the "revolving door" as a discursive black box which contains, simplifies, and obscures the interrelation of the public mental health care system with systems of incarceration and enduring practices of segregation along race and class lines in Los Angeles. I ask what the "revolving door" may reveal about the ways that clinicians in LAPH contextualize their work and how they carry out their work on a day-to-day basis.

In Chapter Two, I consider the specific case of repeated exposure to patients experiencing methamphetamine-induced psychosis in the Psychiatric Emergency Room. Here, I mobilize linguistic anthropological methods to trace a "methy mood" that emerges not only in a given doctor-patient interaction but between these interactions, as rates of methamphetamine use continue to rise among the patient population. The influence and reverberation of the "methy mood" in the Psych ER speaks to the ways clinicians might orient to cycling patients and the ways in which political and cultural ideologies beyond the institution—ideologies about drug use and the drug war, for instance—inform the way clinicians may think, speak, and act in response to drug-related cases. In the process, I look to the ways clinicians have learned to negotiate how they recognize, diagnosis, and treat patients experiencing methamphetamine induced psychosis according to institutional guidelines and individual moral sensibilities about care and treatment.

Finally, I consider the ways that institutional models of safety, danger, criminal and patient are negotiated in the psychiatric units at LAPH. Chapter Three examines the cultivation of similar yet competing vigilant sensibilities by clinicians and law enforcement professionals at work in the psychiatric units. Considering a tragic case in which a patient experiencing psychosis was informally diagnosed with “jail mentality,” I look at the way in which carceral logics of danger and criminality and their attendant racialized ideologies may be integrated into clinical care. While the case considered is explicit, I mobilize this case to attend to how concepts of safety may be used to perpetuate such carceral logics at an everyday, implicit level. Each chapter, attending to linguistic and mooded practices of responding to and being in the hospital, engages the “institution” not as a closed unit of power but as necessarily porous and deeply informed by the “outside,” even as such an “outside” may be obscured. In analyzing such porosity, I seek possibilities for radical, transformative and liberatory ways of being.

Left: A teal button reads "Welcome to the Psychiatric Emergency Room;" Right: Police patrol vehicles parked just outside the Psychiatric Emergency Room entrance

FIELDNOTE ONE

Welcome to the Psychiatric Emergency Room

June 14, 2016, a Tuesday, I arrived to Los Angeles Public Hospital a little after 8:00 am. Unlike the medical emergency department, which is clearly marked and prioritized on hospital directory signage, the Psychiatric Emergency Room (Psych ER) can only be entered through the back of the hospital, or else by winding through unmarked hallways. I entered through the back of the hospital, pausing to put on the hospital ID badge that marked me as a research volunteer. Julia Mendoza, an attending psychiatrist in the Psych ER[1], was not too far behind and we entered together.

We passed through the first door and entered a lobby. We waited for the clerk at the front desk, Evelyn, to buzz us in and as we pulled open the security door, we were greeted by Selena, a patient who was being treated in the Psych ER on an involuntary hold. She was attempting to leave. As medical staff worked to redirect Selena back to the intake office where she would be interviewed, Dr. Mendoza joked: the action was happening right away. I followed Dr. Mendoza

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[1] Medical staff use Psychiatric Emergency Room (Psych ER) and Psychiatric Emergency Department (Psych ED) to describe the space. Here, I follow the most common use at the time, "Psych ER."

down a narrow hallway to a small room at the back of the Psych ER where attending psychiatrists spent their time when they were not with their patients--the "doctor's hub," as I called it in my jottings. There, attending and resident psychiatrists worked updating medical records, making medical orders, and overseeing the flow of patients from ER to inpatient unit or discharge. The Chair of the Psych ER, Henry Torres, was at his desk, busy at work. The unit was already very busy. Two patients were waiting in the intake rooms and doctors had admitted 17 new patients overnight. There were 26 patients on the very small unit. It did not used to be that way, Julia and Henry explained. I asked what they thought had caused the growth in the patient population.

Julia paused, it was a good question, she said, but Henry chimed in right away. The realignment of California Prisons was one cause, he told me. The state was releasing people from the prisons with no support networks in place.[2] Julia nodded. She believed that prison was no place for her patients, but neither was the emergency room. They needed long term care. Next, Julia and Henry pointed to the rise in homelessness and an increase in methamphetamine use across Los Angeles County. Without the state institutions that some patients really need, Henry explained. Patients cycle through our "revolving door," Julia finished. Henry nodded, some patients need to be in long term, locked facilities in order to receive extended care. We are the last resort, Julia continued, or we should be. The fact that we are so over extended, she added is a "reflection of the system failing."

Then, Julia sighed. Today was her birthday and here she was. She usually takes the day off to do something special for herself, but she couldn't today. She had to fill in for a colleague who was at a mandatory "Customer Service Training," which all attendings would have to take.

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[2] For more on the effects of realignment on psychiatric care in California see Chapter Two.

They would all have to learn how to be more empathetic and recognize different emotions. It was insulting, and it was really going to throw the day off. “It’s like training a cardiologist how to take a pulse!” Julia said, her voice elevated. Then, they got a phone call. One of the caseworkers who helps place patients from the ER in inpatient units would be out sick. “Oh no,” Henry said, another hiccup in the day which meant patient cases may pile up.

I was going to spend the day shadowing Bill Walsh, a senior attending psychiatrist who usually worked in the inpatient unit, but spent his Tuesdays helping out in the ER. While I waited for Bill to arrive, I took a quick walk around the unit to get a sense of who was working and how the patient rooms were being used. The two primary rooms were quite full, but there were only two nurses in the nurse station. Others were with their patients. As I circled back to the doctors’ hub, I passed Evelyn and the charge nurse who was working with her at the front desk. They were processing a growing number of patients and their family or friends who were waiting to be seen, and they were still trying to calm Selena down and direct her back to the intake room.

When I returned back to the hub, Henry had received the case files for the day; one manila folder for each patient. The stack was large. Each patient would have to be assigned an attending psychiatrist or clinical social worker for the day. Ideally, this would be a clinician who had already been working with the patient for continuity of care; but since this was an emergency room and patients did not stay very long, that did not always happen. As Henry and Julia negotiated the responsibility of assigning cases, I could hear another nurse attendant approach Selena. Speaking softly and in gentle Spanish, Molly held Selena’s hand and walked her into the office. Henry assigned himself Selena’s case. She had been to the ER so often recently, she had become like an outpatient for him, he explained. I asked Henry if working with Selena repeatedly had changed how he interacted with her. He hesitated. Perhaps, he said, in so far as he had a better idea of what treatment will work and what does not.

Bill soon arrived. After settling in, Henry handed Bill a stack of folders (seven in all) - Bill's cases for the day. Bill reviewed the patient's names, only two that he recognized, which meant the patients he had worked with previously had gone home. He grabbed a piece of computer paper, folded and then divided it into sixths, writing a patient's first name in each quadrant and his own name at the very top. He would use this to keep track of patients as he met them and to guide him as he wrote his notes later. The paper would be shredded at the end of the day, but his name was there just in case it was lost. He would be accountable. After reading over the notes for each of his patients, Bill determined which of the seven should be seen first. One patient would be cared for primarily by a resident doctor, the other by a licensed clinical social worker, Bill would sign off on their notes about the patient after he visited them. So, they would visit those patient's first, and Bill could focus on the others. The two patients Bill had worked with in the past could also wait to be seen as their disposition had already been determined. That left three patients--Michael, Roger, and Carl—newer, potentially more acute cases.

Michael, held in a seclusion or "quiet" room, was our first visit. When he had reviewed Michael's medical notes, Bill learned that the patient was on a 5150 as "DTS" or "Danger to Self." Bill guessed that Michael was unhoused. He looked at the notes of the police officers who had brought Michael to the hospital and confirmed that Michael had been sleeping outdoors for a number of days. "So, you can imagine what we're talking about here," Bill said. He looked over the notes further. The patient had flagged down police and told them he was going to hurt himself. So, Bill concluded, the patient was asking for help. This was good. The doctor who had admitted Michael wrote, "cannot rule out manipulation" in the initial intake note. Bill looked a little closer at the case. Michael was unhoused and had Social Security Income (SSI), he had a long history of involuntary psychiatric commitment at another hospital. Michael had a history of substance abuse. Bill determined that he would have to be sure the patient was no longer using drugs or alcohol or else make sure he was placed on a modified detox to prevent seizures. That was the priority. He took one more glance over Michael's medical record. Eventually, Bill told me, we are going to have to address the manipulation matter, but not now. He clicked on a few older records from previous hospitalizations, including one from another hospital, which he could view because of a county wide software update that allowed for some medical records to be shared between medical sites. After reviewing more, Bill determined that he was not going to address the matter of manipulation. Bill dropped off the files of patients who had already been in the hospital and whose dispositions had been determined with caseworkers who would find and initiate the transfer of those patients to inpatient units for longer term less acute care. Then, we headed toward the seclusion room to meet Michael.

The seclusion room was dark. The air was sour and stale. There were no windows except for a wire-enforced one in the door through which a nurse or nurse attendant could observe the patient (and vice versa). Michael, an elderly Black man, appeared frail and distant, slowly slurping strawberry yogurt as we talked. He told Bill he wanted to go back on antidepressants but had not been able to. He still wanted to kill himself, he told the doctor. He wanted to go back into the room with other patients. Bill stepped out to speak to the nurse in charge of Michael's care, who explained that Michael had been difficult for nursing staff the night before. Bill returned and affirmed that he would include an anti-depressant in the medical order that he made for Michael and also that Michael could return to the larger patient room, if he worked well with his nurses.

We left Michael’s room and walked down the hall to one of the larger patient rooms to meet Roger. Before we entered, Bill stopped and leaned against the wall. When we get depressed, he told me, we can rely on family or friends, our spouses. We have a support network. We can go to the pharmacy and refill our prescriptions. We can ask for an extra hour with the therapist. Not so with people like Michael. When their depression spikes, they do not have the same support system. There is no pharmacy where they can go to easily, no prescription easily refilled. “We are the support system,” Bill explained. We—the police, the emergency room. The only option for patients like Michael is to consider or threaten to hurt themselves. The county is the support system. This, Bill said, nodding to my fieldwork, is where the intersection of the legal and the clinical become very important. With that observation, Bill entered the larger patient room area and made his way to Roger.

When he was reviewing Roger’s medical notes, Bill had determined that Roger had been placed on an involuntary commitment for “DTO” or “Danger to Others.” The medical notes reported that Roger was “irascible,” had broken more than one restraining order and had threatened to kill another man, “John Miles,” (a name written in quotes in both the medical notes and on the patient’s legal paperwork). Roger’s paperwork for his involuntary commitment stated that upon stabilization the patient must be released to police for violating the restraining order. Bill was frustrated. That information should have been the first thing he read when he looked at the patient’s medical records for this stay in the hospital. He would put this in big, bold, underlined letters once he wrote his own note, explained. Bill asked himself why the police had not just arrested this patient. More work for the police, he concluded. Bill read over the notes for more pertinent details. The patient had SSI which is hard to get, but was living in his car despite having government assistance, Bill noted. The patient had been refusing his medication while in the hospital. Bill did not seem to consider the gap between SSI checks and the high costs of rent which might be influencing Roger's living situation.

As we moved from the seclusion room to the larger patient rooms where the majority of patients stayed, my fieldnotes make a notable shift. Though I catch details of the patient's responses, their histories, and Bill's assessments of these patients, I do not capture many details about the patients themselves. Perhaps a sign of my early adjustments to new fieldwork and the process of gathering information in the larger, crowded room. My memory of the interactions themselves is somewhat clouded, and their faces remain blurs. The detail does not reemerge again in my notes until we meet patients again in rooms separate from the larger patient rooms. Though my first response to this gap was disappointment, I see this now as a reflection of the quick pace and crowded rooms in the ER, the turnover of patients through the ER and my experience learning how to do fieldwork in an ethically complex and fast-paced setting.

When we met him, Roger denied having any mental health issues. The restraining orders were "bogus," he told us, and anyone would consider them bogus. He didn't know who this "John Miles" was except that it was someone online who was threatening to hurt Roger's children. He explained that there were a lot of people threatening to hurt him, making threats online. Bill, meanwhile, remained fairly quiet, asking few questions, but taking notes. Bill ended the interaction fairly quickly. And Roger, as he watched Bill walk away, pointed out that even his doctor didn't believe him. Bill stopped and faced Roger. There were two approaches for the issues Roger was having, Bill explained. Either this *was* a mental health issue—in which case Bill could help out, and the medical team could get Roger some medication—or it wasn't and then Bill could not do anything to help. Roger wavered, but ultimately maintained that there were no mental health issues to be considered.

As we were walking out of the patient room, Bill said he felt he had a lot to write down and wasn’t ready to see Carl (the next patient on the list), when James stopped him. James was one of the patients whom Bill had worked with previously and whose case had already been handed over to caseworkers. We stopped to listen. After introducing me to him, Bill sat down across from James on a temporarily empty psychiatric bed. James was hallucinating, he admitted, hallucinations that may have been caused by his methamphetamine use, he concluded. Bill was diplomatic and said that James was likely correct; with a urine sample, they could determine that conclusively and help James get out of the ER faster. James agreed.

James’s concerns managed, we moved to the hallway. Before we reached the hub, Bill paused again and leaned against the wall. He asked me what I noticed about Roger. New to this research, I was anxious but offered that the patient seemed to redirect Bill’s questions about mental health, meaning that I noticed that the patient seemed to be evading questions about illness before he denied it. Bill shook his head “no” and explained. Every time that Bill asked Roger about his mental health, Roger’s energy elevated. The increase in energy can be troublesome in a full room of patients. Bill wasn’t going to “break denial” in the emergency room and assert that Roger *did* have a mental health issue. It won’t help, he explained, and the ER was really not the place for it. The last thing he wanted was a patient to decompensate in such a full room. This would cause more turmoil, made worse by the busy-ness in the unit that day. Safety is the first priority, Bill told me. More work would have to be done for this case. We headed down the hall.

Back at the hub, Bill took a seat at his desk and began to make medication orders for Michael. This was the first priority, he explained, to make sure the patient gets his medication needs met. As he was writing the rest of his notes, Bill got a call from the psychiatric consult service hoping to place two patients who had medical conditions in the inpatient unit for psychiatric treatment. The patients were male; the inpatient unit only had two female beds available. Bill and Julia debated whether the beds could be changed to male beds with much ease (meaning that someone in the inpatient unit would have to rearrange patients in their rooms to make room for a beds in a male patient room). They decided this was not something that they could do and that they would need those beds for two of the many patients already in the Psych ER. Bill told consult that they would have to work something else out and returned to his notes on Michael.

Bill described how he had encountered the patient: eating breakfast in a seclusion room. His next concern, he told me, was affirming whether the patient still qualified for the hold. He was not going to deal with the matter of malingering or manipulation discussed in the previous doctor's note, he told me again. I got the sense that Bill thought this was an inappropriate assessment. Any such malingering was, after all, an attempt to seek care. Michael was extremely depressed, Bill explained. Further, "unlike you or me," he continued, "He can't call and ask for an extra session with his therapist." He has no support system and can't regularly access his medications. Bill looked over the record more carefully. They still did not have labs for the patient. He began to fill out the rest of the template for his progress note and then paused to consider diagnosis. They often see bipolar, schizophrenia and schizoaffective disorder in the ER, serious mental illnesses that may lead to the kinds of emergencies addressed in LAPH. Michael seemed to have depression, Bill explained, but was aggressive with staff the night before.

Bill paused as I considered his reflections and then continued to fill out the remainder of the progress note form for the Mental Status Assessment, which includes: orientation (to time, space, location, etc.); general appearance, motor control, speech, mood, affect, thought process, thought content, perceptual content, insight into mental illness, judgement, and impulse control. Bill explained that thought content was important. Doctors must write if they were able to elicit any delusions or suicidal ideation. This is what was going to “keep him here,” Bill explained. For both legal and insurance purposes, the hospital had to demonstrate that the patient’s case was acute enough to warrant emergency intervention. If the patient was placed on an extended hold later, and contested this hold, Bill’s documentation would be important for the hospital. Meanwhile, a utilization review nurse would be looking over the hospital’s records to ensure they are only treating acute psychiatric cases. Medicaid and Medi-CAL would not cover patient treatment otherwise, and the hospital would lose money. So, Bill would need to make sure it was clear that the patient was still expressing some of the ideation which lead to his hospitalization in the first place. This would be the justification that kept Michael in the hospital. This and Bill’s “Assessment/Plan” entry for the patient. Bill wrote that Michael needed continued monitoring in a highly structured setting. The patient had been there for less than twenty-three hours, he explained. There was still some time to do some good work. A lot of this would be averted, Bill said, if there was some kind of private or consistent care for Michael. He finished his note by making sure that a request was put in to find Michael a bed in an inpatient unit for the remainder of his 72-hour hold.

Bill moved on to Roger. Given Roger’s denial of a mental illness, Bill did not think that Roger would take medication. Still, he needed to make an order anyway, to have the patient’s refusal documented. He made an order of Risperidone, an anti-psychotic medication. Bill continued on with his progress note, including an update on the patient’s continued preoccupation with “John Miles,” his dismissal of the restraining orders against him, and the patient’s continued denial of any mental health issues. Then, Bill wrote in big, bold letters in the first entry box on the page that the patient was on a “police hold” and would have to be released to the police upon stabilization. He included the phone number of the police officer concerned, then reflected on jail. “Jail isn’t a place to care for the mentally ill. It isn’t a place for rehabilitation. It only works as a deterrent for people like ‘you and I’ who aren’t going to break the law anyway.” He would put in a request for the patient to be transferred to an inpatient unit but determined that there was no way the patient would be “transferrable,” because of this police hold. The other hospitals would not take on that responsibility. It seemed, for the time, that Roger would be staying in LAPH for the duration of his hospitalization. He made sure to indicate in the Mental Status Assessment that Roger was “aggressive as a result of his thinking.” These were the kind of notes that would justify holds or else “keep people moving,” He explained. He then returned to James’s note the patient who may have experienced hallucinations as a result of methamphetamine use, making sure the patient was placed on the bed finder, a list of patients ready to be moved to a less acute psychiatric care setting, possibly to an urgent care that could oversee any detox.

After he completed the paperwork, by turned his attention to the patients being overseen by a resident doctor and a licensed clinical social worker on the unit. For the sake of brevity and because I was not allowed to observe adolescent cases, I have shortened these encounters and their clinical outcomes. The first patient, a teenager, would be transferred to a facility that specialized in child and adolescent psychology. The second was a patient the resident doctor on site for the day suspected may be experiencing methamphetamine-induced psychosis. Bill visited both patients and then confirmed methamphetamine use in the second patient. He determined the second patient should be transferred to the urgent care nearby where the remainder of his detoxification from methamphetamine could be safely supervised.

Bill determined that Carl (the patient he had planned to visit earlier) would have to wait yet again as he visited another patient, a young man with whom Bill had already worked and who the nurses had noted was agitated. Before meeting Francisco, Bill looked over the notes. Francisco had tested negative for methamphetamines which, Bill said “means something was going on.” He was not on any kind of stimulant, Bill noted, yet the patient had been on a 72 hour hold a few weeks ago and was here again. Francisco had been described as “assaultive” and “agitated” and received two sedative intermuscular injections yesterday. The doctors had classified him as Dangerous to Others (DTO), Dangerous to Self (DTS) and Gravely Disabled (GD).

We found Francisco in one of the larger patient rooms. Bill reintroduced himself and Francisco and I shook hands. Before describing his situation, Francisco asked for privacy. I stepped away, but then Francisco explained it was fine for me to observe. Understanding, Bill directed Francisco out of the patient room and into an intake office. Francisco took a seat in one of the big, blue plastic chairs filled with sand (so it could not be moved) across from the doctor’s desk. Bill took a seat on the opposite side of the desk and stacked his fists on top of each other to rest his chin. What’s going on?, Bill asked. Francisco was a young Latino man who described himself as currently homeless. He didn’t know where his mother was, and his stepfather had passed away. He had no one, he told us. He could trust no one. In his previous treatment the doctors said he was antisocial, he explained “against society.” Bill asked if Francisco felt like he was “against society.” Francisco said he felt that someone wanted to hurt him. He began counting on his fingers, holding his thumb, then his pointer finger. He did not know if it was the devil, the government, other people or himself in his own head. He grinded his thumb against his temple as he described the possibility that it was his own mind against himself. He wanted help, and he felt like his medication was helping. Bill told him that they would make sure Francisco continued to get Zyprexa. As we walked with Francisco back to the larger patient room, he stopped. “Are you for me or against me?” he asked Bill. Bill patted him on the back. “I’m for you.”

Before we could meet with Carl, Bill needed to make notes for Francisco. Francisco’s 72-hour hold was about to expire. So, Bill began writing the legal formwork necessary for an extended, 14-day hold. “Why write one when it seems we could do this on a voluntary basis?” Bill asked. “Good question, I will have to get back to you on that.” I nodded and pretended that I had indeed asked that question. Bill continued writing. Then he explained. It was important because it may seem like Francisco wants care voluntarily now, but it could become involuntary during the progression of treatment, and he did not want disruptions in care. He noted that Francisco’s behavior had escalated the night before, and that he was “not a happy manic,” so extra safety measures were warranted.

Several phone calls and some paperwork later, Bill was finally able to see Carl. The interaction was swift. We found Carl in the back of the patient room, on the payphone. He hung up and responded cooperatively. He was not sure what was going on, he explained. He had been in rehab previously but had not been on drugs recently. Bill asked for a urine sample, and Carl readily agreed. Bill exited the patient room, and a nurse attendant handed Carl a urine cup. Bill headed quickly back to the doctor’s hub to write a progress note for Carl.

As Bill and I moved through the Psych ER from patient to hub and back again, the unit continued to fill with new patients. The intake rooms full, patients waiting to be seen now lined the hallways of the ER. As a matter of protocol, these patients stayed on gurneys, strapped by their arms and legs and supervised by the emergency technicians who brought them in. Bill passed a patient who appeared to be responding to internal stimuli, talking to himself, as he waited on the gurney. Bill grabbed a clipboard from the hub and performed an intake assessment on this patient. While he was doing this, another patient who was waiting in an intake room began to make noise and an EMT jumped in false surprise and pretended to be scared of the patient. Bill asked her to leave, clearly very annoyed and offended, but she did not, choosing instead to hide behind her partner. Bill returned to his assessment, gently informing the patient that he would be brought into the ER and then confirming that he would get food right away.

When Bill and I returned to the doctor's hub we could see that the doctors had five patients waiting to be seen, much more than were usually waiting at this time in the day. Just as Bill entered, a clerk brought another patient case file back to the doctors. "Oh my god, another one!" Julia exclaimed. Bill decided to finish his notes for the patient whom he had seen in the hallway before helping with any others. When he sat down, he received a call from that patient's mother and was able to discuss his medication history. Meanwhile, a doctor in another department called. He wanted the Psych ER to see a patient with dementia. Bill was annoyed, this was not their purview and was not an urgent or emergent case. The doctor was also annoyed, apparently and hung up on Bill only to call back later.

As Bill was completing the rest of his intake report, the phone rang again. Julia answered, "Chaos in the ER. That's what's going on," she said to the caller. The phone rang yet again. Both Bill and Julia picked up the phone at the same time, saw the other had answered and hung up the phone at the same time. Oh well, the caller would call back. A sheriff deputy who was part of the hospital patrol team and had been on the unit approached the hub and knocked on the door frame. She wanted to know if the doctors were "going to take care of this." Bill explained that they were very busy and would get to it. She left. Meanwhile, Julia was on a call with another doctor. “We are like drowning,” she said. I believe she was calling for back up. The doctor with the dementia patient called again.

Then, a nurse called from the patient rooms. One of Bill’s patients had tried to elope. While Bill addressed that case, another patient was brought in the ER. The doctors now had 7 patients in queue. Bill told me he had not seen the patient intake list this long in quite a while. I felt nervous about the growing list of patients and asked Bill if he felt anxious about it. He told me he did a little, but that he had to work through it and slow down. Rushing to meet others’ expectations would only lead to more mistakes. By the time that Bill finished the remaining items on the medical notes for his patients it was almost 3:00 pm and time for his shift to end. Though he usually did not take on new cases this late in a shift, Bill decided he had better help out. Another doctor who had come to help said that they should prioritize the police cases, that the ambulances could wait. Presumably this was because the police officers were not doing their work as law enforcement while they waited for patients to be seen and it was the doctor’s obligation to help the officers return to work.

Bill grabbed a patient case from the stack and read over the 5150 paperwork; he had trouble reading it. The patient was described as having “severan (sic) mood swings.” Bill read this aloud, confused. “Several?,” Another doctor offered. Either way, Bill agreed, it sounded as though there were discrete mood swings happening. We met the patient in the intake room dedicated for police cases. Though I had not to my knowledge witnessed mania before, I felt immediately that I was witnessing as much when I met Frank, an Asian man in his 50s. He was laughing and asked for water. He sounded dehydrated. I could hear his tongue sticking to the roof of his mouth. Bill handed me a cup, and I ran to get more water. I brought the cup to the patient, but Bill intervened and took the cup from me before giving the patient the water himself.

Frank was in such a state that it seemed that I would not be able to introduce myself and it would be best for less people to be in the room. While Bill interviewed him, I talked in the hallway with the police officers who brought Frank in.

The officers and I stood very close to each other in the hallway as the first told me how they decided to bring Frank to the ER. He was clearly mentally ill, the officer explained. The officer told me about how had undergone two day-long trainings and was going to take another mandatory two day training on mental illness. The second officer chimed in. He said the patient was going through a lot of mood swings today. When they encountered Frank, he was putting cardboard boxes into a bin, but then he started ripping the boxes. The officers told me that they tried to “de-escalate” the situation by directing Frank back to his work with the boxes. Eventually, Frank began kicking at several of the officers, and so they decided to bring him to the hospital. “If he’s threatening us, then he is going to threaten others,” the officer explained. On the way to the hospital, Frank had several mood swings, the officer continued, moving his hand up and down like a car on a rollercoaster. Then, the officer explained, Frank tried to kick out the windows in the car. I asked the officer if he took patients to the hospital often. He told me that he didn’t take them to the hospital as often as he used to but later admitted that he had noticed a spike in these kinds of cases. It was hard to tell though, if the person was mentally ill, on drugs, or both.

Bill finished the intake interview with Frank, passed Frank’s medical file to the nurse who would be caring for him and then returned to the hub. Once there, Bill called Frank’s sister to gather collateral information about Frank’s medical history. He was updated on another patient’s ECG: normal. Bill then turned his attention to Frank’s intake note. He noted the patient’s demographic details—age, ethnicity. He completed the Mental Status Assessment noting particularly the patient's mood lability. He turned to write his assessment and plan of care for the patient. "Always justify the hold," he told me, before turning to complete the written 5150 paperwork for Frank.

Bill turned his attention to the medical tests that he had ordered for previous patients. He got a call from the nurses in the larger patient room. Frank's behavior had escalated further. After hanging up, Bill made sure an order for Zyprexa was in Frank's file. He got another call. Frank had upset several of the patients in the unit, including two of Bill's patients. The nurses put Frank in restraints. Bill began looking over the nurse's report on Frank's restraint when a resident doctor, Tom, arrived for the night shift. Tom ate from a bag of chips and offered Bill one, as Bill began to review his cases. In sum, he explained, it seemed a few patients were acting out in one of the larger patient rooms, and it would be Tom's decision how to manage that. "Oh," Tom replied," I think I'm going to keep the room very quiet."

After reviewing his patients with Tom, Bill looked over his paper. He still had a few medical notes to finish. The phone rang again. This time, another one of Bill's patients was very upset, and the nurses wanted Bill to come to help. We walked down to the patient room. Several nurses and nurse attendants were standing in a semi-circle at a wide distance around the room with the patient at the center. Another doctor was talking to the patient and had to talked him into taking medication but not without five minutes of negotiating, she explained. The patient was very upset.

Frank, meanwhile, was straining in his restraints. Then, James, the patient who had stopped Bill earlier, became upset. He noticed a few dents in the wall near the bed by the window and pointed them out to a nurse. He promised he did not make those dents. The nurse said that was true; those dents had already been there. Bill, meanwhile, convinced James to sit down and made sure that James had his medication. He turned to the patient who was still upset and talked gently, moving closer to the patient. Eventually the patient sat down.

Calm restored in the unit, Bill returned to the hub. He made final edits to his medical notes. Reviewed, added addendums where needed and then signed off on the cases that he was supervising. He completed the exiting paperwork for yet another patient. Notes finished, Bill took a moment to breathe. By now it was very late in the day. Another patient arrived, loud, and agitated, but they would have to be seen by the doctors on the night shift. Bill gathered his belongings and signed off for the day, heading back to his personal office. After thanking him, I grabbed my bag and headed back the way I came, exiting through the back of the hospital and through a parking lot, past the police vehicles that had brought more patients.

CHAPTER ONE

Mapping the "Revolving Door": Discursive and Political Histories of Involuntary Commitment in California.

Early in my fieldwork in Los Angeles Public Hospital (LAPH) and new to the ins and outs of emergency psychiatry, I caught up with David, a psychiatric nurse, after he had finished checking on his patients and administering their morning medications. A big, tall man, David drew his coworkers in with jokes, nicknames, photos of his infant daughter, and ice cream treats during breaks. He was charismatic and jovial. "You have to laugh to survive this place," he often told me and soon I learned to laugh with him. Laughter and joy were necessary, he explained, in order to continue work in the psychiatric emergency room, necessary for managing the ongoing exposure to others' mental distress, the pace, the cycle of patients in crisis.

Over time, I saw David's jokes as a reflection of the seriousness with which he took his work. In addition to the 12-hour shifts he worked in the ER, David was also a union representative for his fellow nurses and took extra classes on nonviolent de-escalation measures for patients in crisis. That morning, I joined him as he sat down at one of the computers in the nurse station to begin writing notes on the patients under his care. David paused briefly before logging on to the computer to show me a recent picture of his daughter who was about the same age as my niece. Then, after a few moments remarking on her infant brilliance and beauty, he turned his attention to his work and to the patients pacing in the room before him.

Glancing through the window of the nurse station and into one of the large patient rooms, David reflected on the state of public mental healthcare. Deinstitutionalization of state hospitals had changed the way patients who needed care received it, he explained. The ER is a "revolving door," he told me and paused, smiling, to ask why I was not jotting down his wise observations. Obediently, I took out my notebook. David gestured to one patient in particular pacing back and forth down the aisle between beds. Dr. Henry Torres, the chair of the emergency department, had just signed off to release the patient directly home. The patient, a tall, pale young man with a round face and bedhead hair pressed his head against the nurse station window directly in front of David and his computer. Rolling his face back and forth across the glass, the patient cried. David gestured subtly, nodding his head toward the patient. He was not ready to go home, David sighed. Look at him. The patient was going to come back, David explained. He should stay in the hospital, but legal protocol dictated otherwise.

David continued: Most patients who come into the ER really need help. Though *some* were there for "three hots and a cot," he conceded. According to David, some hospitals approached the "revolving door" patients or the "frequent flyers" by making the space as uncomfortable as possible—hard beds, bright lights—a practice that assumed these patients did not need care. The approach had changed, but patients still did not get the long-term care they needed, David continued. With that brief reflection, he returned diligently to his work. Fourteen days later, David's pacing patient returned to the psychiatric emergency room.

A few weeks later, I caught up with David again while he was working as charge nurse at the front desk, overseeing initial triage, assigning new patients to nurses, answering phones. I asked if I could observe and David consented. I had not been feeling well, and, so, was grateful for a fieldwork day spent mostly seated. A familiar patient entered the ER on a gurney, accompanied by EMTs. Selena, a patient whose care Dr. Torres always made a point of supervising to ensure consistency, was back in the ER after only two days. Dr. Torres had tried coordinating with her outpatient doctor, but apparently their treatment plan had not worked. David, having worked with Selena, told me a bit about her life history, not surprised that she had continued to experience ongoing cycles of distress that brought her back to the ER again and again. It was difficult to work in the ER, he continued, elaborating further on his "laugh to survive this place" strategy. You only see the most acute cases and only for a while. You rarely see people improve beyond stabilization. They often come back. David's past experience working in inpatient units kept him hopeful, however, and he held onto the fact that he had witnessed many patients stabilize and recover. Later, during a lull in the work, I asked David to visualize for me how he understands what the mental healthcare system in Los Angeles does for poor and otherwise vulnerable patients, like those who found their way to LAPH. He obliged, taking time to draw a map of his understanding.

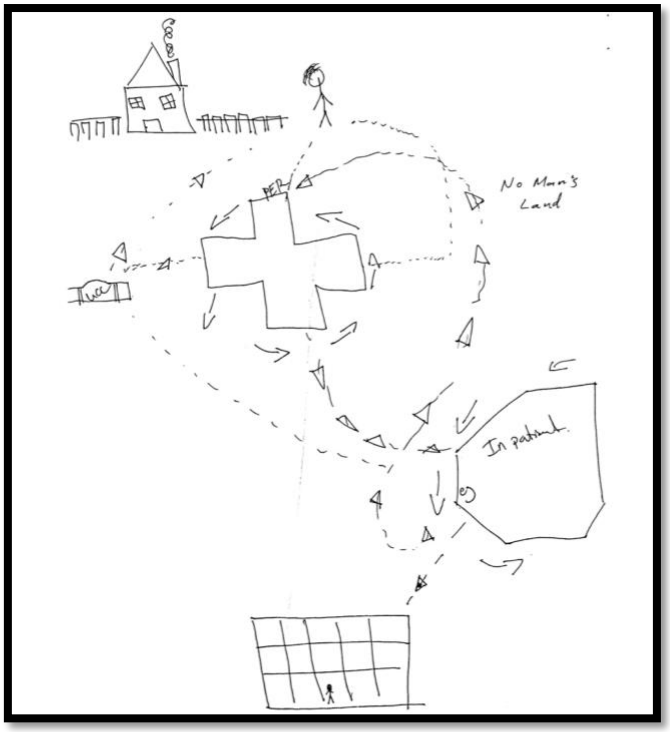
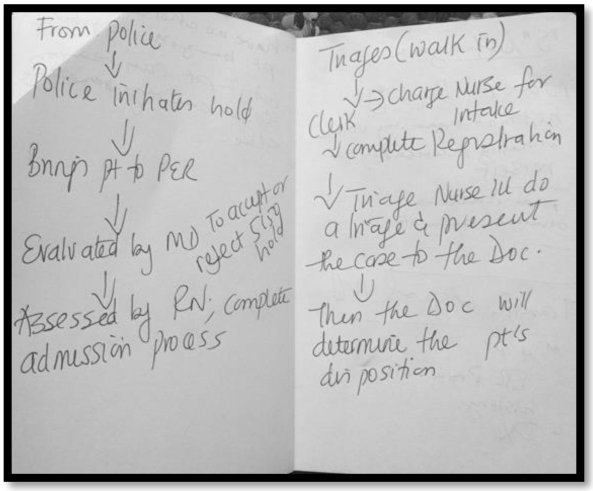


Figure 1: David's Map. At the top, a patient enters the Psych ER from his home or the streets of LA. To the left, David has drawn an Urgent Care Center where patients may be transferred for stabilization. To the right, he has drawn an inpatient unit like the one at LAPH. At the bottom, a locked Institution for Mental Disease (IMD facility) where some patients may be sent for extended care. To the right of the PER, David has labeled a blank area "No Man's Land."

At the center of David's map was the Psych ER (labeled in the drawing above as PER). Patients entered the ER from home or the streets, he explained. From there, a patient could be sent to any number of facilities. David quickly drew circles of arrows around the hospital and inpatient units explaining that they were all “revolving doors.” Then, he drew arrows around and between the buildings. To the right of the hospital, he labeled a blank space “No Man’s land.” If a patient did not have a home or support network, David explained, they were likely to wind up in “No Man’s Land,” and from there, return to the Psyche ER or else be sent to jail—an institution noticeably missing from his map. David finished the map by drawing dotted lines around each space to indicate the confusion of individual patient trajectories, like eddies that might sweep a person up and into one revolving door or another depending on the currents or the resources a patient had to keep out of “No Man’s Land.”

Though I would ask many clinicians to draw their understanding of the mental health system, David’s drawing of the patient experience from home to hospital to “No Man’s Land” and back again was the least linear, but in my opinion most reflective of descriptions of the public mental health care system shared by others. Throughout my fieldwork, circular metaphors and the notion of the “revolving door” dominated explanations of the public health care system as it operated in LA.



From Police
↓
Police initiates hold
↓
Brings pt to PER
↓
Evaluated by MD To accept or reject 5150 hold
↓
Assessed by RN; complete admission process

Triages (walk in)
↓ → charge Nurse for intake
Clerk
↓ complete Registration
↓ Triage Nurse will do a triage & present the case to the Doc.
↓
Then the Doc will determine the pt's disposition

Figure 2: Two patient experiences drawn by a psychiatric nurse. In the first image: to the left, the trajectory for patients brought in by police. To the right, the trajectory of patients who come in on their own or with family and are brought to triage. No description is made for what happens before or after the patient enters the hospital.

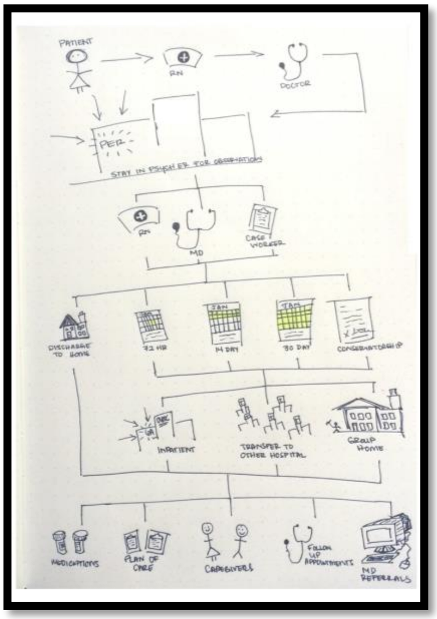


Figure 3: Another map drawn by a psychiatric nurse who worked the nightshift. Here, the patient trajectory is elaborated slightly differently, a tree diagram, more like a gameboard. The patient enters the hospital from an undefined place, encounters nurse, then doctor and is held in the Psych ER for observation. Doctor, nurse and caseworker determine the next steps for the patient (72-hour, 14-day, 30-day holds and then conservatorship or discharging the patients to home). If the patient is held, they are transferred to inpatient units, other hospitals or group homes. Once they leave the clinical space, the patient may have several resources available: "medications," a "plan of care," "caregivers," "follow-up appointments" and "MD referrals."

Indeed, the "revolving door" has become popular in medical and legal discourse when discussing "high" or "super utilizers" and the consequences of hospital stays shortened by managed care models (Jenkins and Csordas, 2020) and rates of criminal recidivism in jail and prison populations. The metaphor weaves through public health, legal and popular media since at least the early 1940s (See for instance: OED "revolving door" n.b). For the interests of this chapter, it is especially predominant in local administrative and legal reports about the effects and outcomes of California's laws on involuntary psychiatric commitment (See for instance: Task Force Report 1999; Carico and Spar 2010; Grand Jury Summary 2014; Senator Report 2019).[3]

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[3] For instance, local probate law firm Carico, McDonald, Kil and Benz LLP released a report in 2010 entitled "Trusts & Estates: Escaping the LPS Revolving Door" (LPS refers to the Lanterman-Petris-Short Act which established the state's involuntary commitment laws).

In these texts and in the everyday narratives recounted by my interlocutors the “revolving door” metaphor is used variably, though not universally (The second image in “Figure 3,” for instance, indicates something more like a gameboard articulation of the system than a revolving door). Nevertheless, it is fairly ubiquitous. Hospitals and other institutions may be “revolving doors.” The interaction of multiple systems may be a “revolving door.” Even someone receiving care may be called a “revolving door patient” or else have a “revolving door syndrome” (cf. Tate 1991, iii). It is a metaphor that describes both event, experience and subjectivity. Its prevalence and wide acceptance bely a commonly shared biomedical narrative in public health about the relative function or efficacy of emergency care (cf. Mattingly 2010). When it is used in the context of involuntary psychiatric commitment in Los Angeles, “revolving door” represents a legacy of interactions between the medical and legal systems reflected in the idioms used by those nurses and doctors working on the ground and how clinical professionals not only understand and contextualize their work, but, indeed carry out that work.

The “revolving door” (like any metaphor) functions in its everyday use as a conceptual framework for grasping not only the complicated and intertwining histories of health care and criminal justice systems in LA, but the lived consequences of these histories for patients and their caretakers and the everyday practice of emergency psychiatric work (Lakoff and Johnston 1980, Santa Ana 1997). It is worth, then, taking the “revolving door” seriously not only as an “infelicitous metaphor” (Jenkins and Csordas 2020) but as a conceptual framework that guides how health care is understood and practiced. While some medical and legal professional participants in my research have called their respective institutions “silos” of knowledge and information—that is, discrete and closed circuits—I see in a metaphor like the revolving door critical and yet disjunctive flows between institutions that may elaborate this sense of “siloed” knowledge. As will be seen in this chapter, both the “revolving door” and “silo” have deep cultural and historical roots in the construction and reformation of California’s public mental health care system.

Alongside the “revolving door” exists “No Man’s Land.” In David’s account, this is a space where patients are particularly vulnerable to “revolving doors” of medical and carceral institutions whether for lack of financial resources or other forms of support. “No-mans-land” from the 14th century English “nonemanneslond” was the “name for the unowned waste ground outside the north wall of London, the sight of executions” (Online Etymology Dictionary, 2020). It was later popularized during WWI as the site between entrenchments, a site of particular vulnerability. Though David was the only person to use this particularly apt metaphor, it speaks to another phenomena that often happens alongside evocations of the “revolving door” and in discussions of the public mental healthcare system: a cluster of unknowns about the ins-and-outs of institutional spaces in Los Angeles. In my research, I see glimpses of “No Man’s Land” when clinicians describe the absence of support networks for their patients (See for instance, “Fieldnote One,” 22, 26, 30) or draw blanks when asked to describe what happens to patients once they leave for the hospital.

Consider, for instance, another “map” drawn by an inpatient psychiatric nurse when I asked her to describe what happens to patients who leave LAPH. Rather than draw, and a bit perplexed that others might have different ideas (“Wouldn’t we all just have the same thing?”) Tami described how she understood a psychiatric patient’s trajectory through the mental healthcare system.

1. How **I *think*** it happens, you know, that they’ve—
2. **wherever they’re at** an ambulance or police pick them up.
3. Bring them here to the Psych ER or to Medical,
4. depending on the reason, because sometimes they’re OD’d.

5. Then, they go to the regular ER.
6. They get cleared medically and then they come to the Psych ER.
7. [Somewhat inaudible: Transfer to Inpatient].
8. Stay with us for however long and depending,
9. they'll go to a shelter or a Board-and-Care.
10. **I think** it's better when they go, like an IRF, an Intensive Residential Facility,
11. because then it's a minimum of six more months and that way,
12. **I think** that they have a better chance, because they're off drugs for longer.
13. Gives them a better chance of staying away.
14. They have a follow-up appointment at mental health centers,
15. which are everywhere, so that they can get the refills.
16. And then **I just—I don't know.**
17. I mean **who knows** what happens? Really. After that?
18. Once we've done everything we can,
19. they're either going home with their parents or they're going back to the streets.
20. And you know, somehow, **it seems to come back full circle.**
21. And either they stay gone and we never see them again,
22. or they start the process over. I mean, cause, really.
23. Once they go—Once we do the discharge to **whatever place—**
24. Once they leave that place, that's the—**that's the area we don't know about.**
25. You know, for however long they're gone
26. until we get the next admission note as to why they were picked up.
27. You know, there's—but, it does seem to,
28. I mean, it just seems like **they just keep revolving** and
29. I know we've got staff here that works at other places, like X,
30. and **we don't know** them but they're like "Oh, I know him."
31. I hear that all the time
32. . . . from what I gather, **they just go from place to place to place.**

Though later in the interview, Tami acknowledged moments when she had seen people in mental distress and even former patients outside clinical contexts, here, the space beyond the hospital remains obscured. Patients are picked up "wherever they're at" (line 2). They are discharged to "whatever place" (line 23). Then, having left "whatever place," they enter "the area we don't know about" (line 24). In this account, "knowing" is a fraught act. While Tami begins the narrative with "I think,: (lines 1, 10, 12) she eventually shifts to engage a kind of collective knowing or not knowing moving from "who knows" (line 17) to "we don't know" (lines 24 and 30). Engaging the first-person plural, Tami adopts an institutional, not individual perspective. In the process, toward the end of her narrative, allusions to the “revolving door” and cyclical movement of patients through the mental health care system emerge: “It seems to come back full circle” (line 20); “they just keep revolving” (line 28); “they just go from place to place to place” (line 32).

Over time, I have begun to understand the emergence of the “revolving door” and “No Man’s Land” in conversation with my research interlocutors as paired. And, in that pairing, the two work as a kind of discursive black box for describing the cooperation of various institutional spaces including mental health facilities, jail and prison facilities, government housing and supportive care facilities as well as the liminal spaces between such facilities (i.e. “the streets”). The “black box” has been used traditionally in cybernetics to describe a system whose inputs and outputs may be known but whose internal mechanisms remain obscured. The “revolving door” as discursive black box reflects such obfuscation. As a black box for the unknowns of institutional operation, “revolving door” reflects both institutional discourse—a shared language which is used in medical and legal scholarship and in turn is adopted by nurses, doctors and law enforcement alike—and institutional perspective—a constrained attention to the work of the institution itself. Here, institutional discourse and perspective function to decontextualize the operation of the public mental health care system from the city or communities in which the institution operates and, to some degree, the other institutions in which it functions. What emerges is an “institutional world” with determined yet open horizons of possibility for being-with others (See “Introduction;” Butler and Salamon 2017; Guenther 2013).

So, even while perspectives reflected in “revolving door” discourse may be constrained or otherwise obscure the interrelation of various public institutions and systems (i.e. public mental health care, housing, incarceration), it nevertheless reveals a great deal about such systems and the people who work within them. At an institutional level, for instance, such a metaphor may tell us that the operation of such systems is often characterized by repetition and movement without progress. “Revolving door” patients are those subject to this repetition and stalled progress. Along the way, people subject to the “revolving door” are framed as patients in constant or near-constant crisis, relying or dependent upon the institutions in ways that obscure or deny individual agency and the agency of their non-professional caregivers. Indeed, Jenkins and Csordas (2020) mobilize the “revolving door” metaphor to contextualize the experience of adolescent patients who have been subject to repeated and short hospital stays (Chapter 2, section 6). Mobilizing this metaphor, they describe a phenomenon involving “a longer and cyclical narrative temporality, one that connotes long-term frustration that could undermine hope for the future and that also bespeaks the influence of repeated encounters with the bureaucratized mental health system (Chapter 2, Section 9, para 2).” Meanwhile, those working within or for “revolving door” institutions likewise lack agency in their repeated, bureaucratized encounters with patients. Or, rather, the agency they have as “street-level” bureaucrats whose everyday decisions inform the outcome of individual patient treatment and may reify bureaucratic policy (Lipsky 2010) is obscured by the seemingly autonomous movement of the “revolving door.” In this way, the “revolving door” can be seen to operate as a perpetual motion machine, one which nurses doctors and other medical and legal professionals cannot control, but only describe. The forces which started the spinning and which maintain its motion are beyond reach, beyond knowing.

Yet, the historical record tells a different story. In the remainder of this chapter, I turn to archive, attending to various metaphors that framed both the conceptualization and reformation of public mental healthcare in California, particularly as it relates to involuntary commitment procedures. In the 1960s, at the end of a period of significant social welfare reform and at the eve of broad, national neoliberal economic reform, California legislators took on the involuntary commitment laws of the state as a path toward deinstitutionalization. There, in the debates around danger, public safety, and institutional/individual responsibility and agency, I find the initial push-pull that started the cycles of temporary care and incarceration so remarked upon by research interlocutors in the 2010s. This reformation speaks to a longer history in California of carceral mental health care (i.e. those forms of care which hold individuals against their will) and an ongoing debate in which the "revolving door" has become a critical metaphor for reformation.

Instead of considering the period of deinstitutionalization as a total reformation of the mental health care system, I consider the deep ties California's mental health care system has always had to penal incarceration and the management of poor populations. From this perspective, deinstitutionalization looks more like decentralization and dispersal of the institution between health care, housing, and penal institutions. This is not an argument that supports the notion that prisons have become the "new asylums" or one that neatly follows theories of "transinstitutionalization,"[4] though decades of funding cuts to the mental healthcare system and funding increases to the jail system have led to such phenomena as the LA County jail system's infamy as the nation's largest mental health facility (cf. Prins 2011; Stone et. al. 2011; Ben-Moshe 2017; Ben-Moshe 2020). Rather, I take a perspective drawn from my analysis of the use of "revolving door" metaphors, which understand the operation of the public mental health care institution as at once constrained to a given space and also influencing and influenced by the

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[4] Transinstitutionalization broadly describes the phenomena whereby patients from one institutions (the mental asylum) are cycled through other institutions, primarily jail and prison systems. While the approach described here recognizes such phenomenon it takes a less clean and tidy approach, recognizing the variable ways funding, the criminalization of those with mental disorders and those who are unhoused, and the diagnosis and treatment of mental disorders has changed.

revolving doors of other institutions of criminal incarceration, services for unhoused people, and popular political understandings of such institutions. While many may view "deinstitutionalization" and the reformation of involuntary commitment procedures as a constraint on psychiatric power, I consider the ways such progressive reforms over time further extended the scope of psychiatric practice into the broader realm of managing public safety often in opposition to the medical mandate to provide treatment for those in need. In the process, I consider not only how some become subject to the movement of the "revolving door" but how clinicians likewise become practitioners of a kind an approach to care whose influence cycles sporadically between and extends beyond any singular institution. Along the way, rather than orient toward the history of deinstitutionalization as a policy "pendulum swing" (another commonly used metaphor) and complete shift in direction for psychiatric care, I consider it as a diffuse, ongoing, and indeed, *revolving* reform. Looking at the historical and cultural mechanisms which keep this revolution moving, I attend to enduring histories of white supremacy, heteropatriarchy and capitalism that ensure—especially in Los Angeles—that people of color and people experiencing poverty will be those most often caught in the spin of the "revolving door." Turning at the end to an interview with the Chair of the Psychiatric Department at LAPH, I consider the phenomenology of the "revolving door," which obscures structures of inequality and informs how clinicians experience their position within these structures in everyday life and practice.

“Memory as it flashes up at a moment of danger”: Writing histories of psychiatric care in the twenty-first century

> “History is the subject of a structure whose site is not homogenous, empty time, but time filled by the presence of the now.”
> – Walter Benjamin, “Theses on the Philosophy of History”

Writing a succinct history of involuntary psychiatric commitment policies, practices and procedures in California and their consequences is a frustrating task to say the least. There is much to negotiate in the archives of memoirs and analyses, legal formwork, government reports, news media, and the many, many histories, genealogies and analyses that have been written on mental health, madness, and psychiatric practice (See for instance: Ben-Moshe 2020; Braslow 1997; Caiola 2020; Foucault 1988, 2004, 2008; Goffman 1961; The LPS Task Force 1999; Lacey 2015; Saks 2002, 2008; Scheff 1999[1961]; Scull 2016; Sedgwick 2015[1982]; Subcommittee on Mental Health Services 1965). Historians, doctors, lawyers, social workers, academics, activists, and people who identify variously as psychiatric patients or survivors themselves all have documented the emergence, scope and function of psychiatric commitment to divergent and often competing ends.[5] These histories emerge, too, in the everyday lives of those enacting such care, in their reflections on the work and in their attention to patients receiving care (See: Chapter Two).

Rather than aim for a completed history, then, rather than attempt to pinpoint an origin for this history, I work instead to describe the history of conditions—public discursive, political, economic and cultural—which make contemporary involuntary psychiatric procedures and the cycles which so often characterize them possible. This is a history of political and cultural

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[5] The notion of involuntary psychiatric commitment itself has been traced as far back as the 4th Century B.C.E. to Hippocrates who is credited with suggesting those with mental disabilities “be confined in the wholesome atmosphere of a comfortable, sanitary, well-lighted place” (Brakel 1985 as referenced in SAMHSA 2019) and the development and enactment of involuntary commitment along ethical and political lines has been the subject of many treatises (See for instance: Perlin 2012; Saks 2002).

contingencies that charts the emergence of the contemporary public mental health system in California as one which is necessarily incomplete, ongoing, and diffuse (cf. Foucault 1977; Ben-Moshe 2020). I also write from the perspective of an emerging present to explore the archives of mental commitment with an awareness that the present conditions in which I live and write, the conditions in which the people I work with live and work, necessarily inform my reading and the historical narrative I tell.

In his "Theses on the Philosophy of History," Walter Benjamin writes: "To articulate the past historically does not mean to recognize it ' the way it really was' (Ranke). It means to seize hold of a memory as it flashes up at a moment of danger. The danger affects both the content of the tradition and its receivers (2007 [1968], 255)." Here, recognizing that I cannot travel through the archives to rescue a "truth" as it were, I seek instead to recognize the dialectical relationship at work between past and present "dangers," those conditions which motivate people to interrogate the past to understand crises in the present. I am not seeking to imbue the present with a prescient past or read the present into past conditions. Rather, I seek to preserve the difference between past and present while insisting that this difference is unstable, interdependent and mutually informing (cf. Gadamer 2006[1975]; Foucault 1977, 1988).

What is the moment of danger in which I write? Why do I perceive it so? I write in a moment during which the US criminal justice system continues to operate primarily through penal, carceral means. That is, the great majority of crimes regardless of their origin or impact—theft or assault, trespassing or murder—are responded to with the same punishment: incarceration, a practice of punishment which disproportionately effects Black, Indigenous and people of color in the US (See for instance: Wilson Gilmore 2007; Gramlich 2002). I write in a moment, too, where temporary involuntary commitment of people with mental disorders is an increasingly prolific means for treating people in mental crisis (Lee and Cohen 2020) and where family members finding few or no other options actively and openly advocate for the restraint of their loved ones and the restriction of their civil liberties in the name of treatment and care (See for instance: Rosenberg and DuLong 2019). Though the data are limited, as will be discussed below, there is evidence that involuntary commitment (at least in public facilities) is used more often on people of low socioeconomic status (SES) and people of color (Swanson et al. 2009; Hankerson et al. 2015; Ochoa et al. 2015). This bespeaks a history of systemic racism understood as the "state-sanctioned or extralegal production and exploitation of group-differentiated vulnerability to premature death" (Gilmore 2007, 28). So, it is not the acts of individuals alone (though some may be of concern) but rather the systematic shifting of priorities over time that leads some people, particularly poor people and people of color at risk to systems of involuntary care and incarceration and their many revolving doors.

I want to be careful here, however, and rather than condemn the practice of involuntary commitment outright, I want to emphasize its function as the primary means by which many patients and their family members seek and achieve access to mental health care. Careful distinctions must be made between the therapeutic or purportedly therapeutic value of containment for those who need care and the incarceration of those accused or convicted of "criminal" behavior. Nevertheless, these practices often blur to troubling ends, especially when considering their demographic similarities (Ben-Moshe 2017, 2020). Further, (as will be discussed in Chapter Three) the enactment of involuntary commitment to therapeutic ends may risk reproducing traumatizing carceral practices of the criminal legal system and criminalize patients in distress. The troubling demographic and often ideological overlap of these two practices bears out in the history of involuntary commitment, particularly in California.

Demographic data on people who experience mental health crises, are incarcerated or have been unhoused in Los Angeles is scattershot to say the least. While efforts have been made to gather reliable data, mapping a person's relatively quick movement through and across multiple county bureaucracies (as a result of their "revolving doors") is difficult. There are estimates however, that give an idea of the current crisis in Los Angeles and which may speak to the sense of frustration or resignation that sometimes accompanies narratives about the "revolving door" in LAPH. In January 2020, the Los Angeles Homeless Services Authority (LAHSA) estimated that 66, 436 people were currently living unhoused in the county with 26 % of this population reporting long term mental health conditions (2020). These estimates—representing a population the size of a small, American city—indicate the number of people who were counted as unhoused during a single weekend in Los Angeles and are likely an undercount. Meanwhile, in LA's jail system (the nation's largest) between 3,000-5,000 people identified with mental illnesses are incarcerated on any given day (Brooks Holliday et.al. 2020; Walker 2020; Westervelt and Baker 2020). Though the data are limited, what data are available indicates that many thousands arrive from jails and the streets of LA to psychiatric emergency centers like the one at LAPH every year (Ochoa et. al 2015). COVID-19 has caused complications in more up-to-date estimates as the county's policies for sheltering the unhoused, jailing, and hospitalization have been detrimentally and chaotically impacted by the pandemic.

These estimates reflect an enduring concern at the state and municipal level about population and population control that has dominated public health discourse since California's very first days as a state. The legacy of racial segregation, discrimination (particularly anti-blackness) in the form of redlining (Rothstein 2017), predatory eviction practices (See for instance: Desmond 2016) and the targeted, hyper-policing of LA's Black and brown.

communities (Ayres and Borowsky 2008) is reflected in smaller demographic breakdowns of such populations. Racial disparities in LAHSA's homeless count were prevalent in 2019 and remained the case in 2020. While only 7% of LA County residents identify as Black, Black Los Angelenos represent 33% of the county's unhoused population (LAHSA 2020).

Similar disparity can be seen in LA's criminal legal system. Though the number of people incarcerated is variable from day to day, an estimated 29-31% of the LA county jail population is Black (Marcellino 2020) and an estimated 41% of the mental health population identified within the jail is Black (Appel et al 2020). Meanwhile, though Latinx people represent 49% of the LA County population, they comprise 52% of the county's jailed population and 35% of the jailed mental health population. While those identified as White represent 52% of LA County's population, they comprise only 12-15% of the jailed population and 19% of the jail's mental health population.[6] The limited data available in the psychiatric population in LA's public hospitals suggests that Black patients are disproportionately represented among those who receive mental healthcare on an involuntary basis (Ochoa et.al. 2015). LA County has three public hospitals with psychiatric emergency departments, but only two reported data for a study on psychiatric emergency services outcomes. Of those two hospitals, Black patients comprised 30% and 13% of the patient population. While these numbers reflect the segregation of LA County (with the hospital in the south serving a larger Black population) they nevertheless are disproportionate even when these geographical differences taken into consideration.

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[6] These data sets are striking. On the one case, they may suggest that Black Los Angelenos are more likely to identify or be identified as having a mental disorder and receive mental healthcare in jail while Latinx people who are incarcerated are less likely to identify as having a mental disorder or be identified as such. Meanwhile, the higher rate of white people receiving mental healthcare in jail may similarly be the result of self-reporting and identification and may also reflect enduring discrimination that suggests white people who commit crimes are "mad not bad" (see for instance: Grekin et al 1994).

While most people of lower SES and unhoused people have been targeted for incarceration in Los Angeles as a matter of controlling “surplus” population (See for instance: Lytle-Hernandez 2014) and appear more likely to be subject to involuntary psychiatric commitment (Ochoa et al. 2015), these class demographics cannot be separated from racial demography or the previously mentioned targeted practices of segregation and policing that have shaped Los Angeles. These disparate rates of incarceration, psychiatric commitment, and inadequate access to housing cannot be separated from the deep structural and systemic racism that persists in Los Angeles today (cf. Hall 1977). Such localized forms of systemic racism influence how people of color are subject at greater rates to such things as “revolving door” syndrome and the constant crisis and criminalization it represents in the “institutional circuits” between pubic mental health care, housing and incarceration systems (Hopper et al. 1997). Attending to metaphors used to discuss these systems and their intersections, like “revolving door,” means looking closely then, at the ways they obscure or reveal these inequalities, policies that are modeled on largely white, middle class ideologies of health, and their consequences for patient care.

From Railroad to Revolving Door:
Reforming Public Mental Healthcare in California

In the early ‘60s, California State Legislature, like many governing bodies at the time, began to reconsider the use, function and ethics of state-run mental asylums for the treatment and confinement of those deemed “insane” or disabled. In 1965, Jerome Waldie, the Democratic majority leader of the State Assembly Ways and Means Subcommittee on Mental Health Services and his staff assistant, Arthur Bolton, took up the charge (Bardach 1972, 101). After reading reports on the cursory nature of civil commitment procedures (on average taking only

4.1 minutes) and psychiatric evaluations (taking only 5 minutes),[7] Waldie and Bolton determined to reform the often overlooked but crucial involuntary commitment laws in an effort to decentralize the state's mental health care system (ibid, 102). As Bolton explained: "We saw that if we could lodge a huge boulder in the center of that overused road to the mental hospital, the patients would have to be sent somewhere else, to more appropriate facilities. The system would *have* to move off dead center" (ibid, 103).

While this effort of reform was in keeping with a broader and growing national call for the deinstitutionalization of mental healthcare and the creation of community-based care options, it also speaks to a much longer and more contentious history in the political, cultural and ethical debate about psychiatric care and its purview in California; highlighting the moral and moralizing function of involuntary care, the constitutionality of such care, and function of psychiatric care in either protecting the "public" or caring for those in mental distress. Indeed, these tensions represented a dilemma for law makers of the 1960s and bespoke century long tension in California between public psychiatry's role in enacting the police power of the state to protect the life and property of others with the role of enacting *parens patria,* that is, the power of the state to care for those deemed incapable of caring for themselves (cf. Bardach 1972; Anfang and Applebaum 1984).

To move the mental healthcare system "off dead center," legislators suggested a new system of temporary involuntary commitment limited initially to a 14-day hold. At the end of 14-days, all patients would have to be released. Such a dramatic change in the indefinite confinement of people in mental distress was met with praise and consternation. After a great

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[7] These studies were written by Dorothy Miller, a student of Erving Goffman, and William Austen Wilde, a student of Thomas Scheff, respectively.

deal of political wrangling, financial negotiations, concessions and hundreds of amendments, The Lanterman-Petris-Short Act (LPS) was passed. Though the committee had been cognizant and indeed scrutinized the dilemma posed by obligations to care and public safety, LPS doubled-down on some aspects of this dilemma outlining a series of commitment procedures including the legal parameters for 72-hour, 14-day and 30-day commitments for those people who by reason of a mental illness are considered a danger to self (DTS), a danger to others (DTO) or gravely disabled (GD). The LPS Act set an example for the rest of the nation. While the mechanisms and procedures vary across states, by the late 1970s every state in the country was "following an exclusively dangerousness-based approach to civil commitment" (Applebaum 1984, 144).[8]

After reviewing the politics and legislative dilemmas of involuntary commitment in California prior to the 1960s, I take a closer look in this section at "The Dilemma Report," a study released by California Legislation advocating for reform, and the fraught and almost failed passage of LPS in the late 60s. In the process, I trace the public and political articulation of state power to police and *parens patriae* as key tensions that informed legislation and the construction of infrastructure in the decades to come. At the heart of this tension are often-xenophobic and class-based articulations of mental health and dangerousness that served over centuries to criminalize people with mental disorders and establish the tenuous but enduring links between criminal carceral and public mental healthcare systems in California, forming the initial paths that would make the "revolving door" such a common metaphor and institutional way of seeing.

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[8] Though California is often credited as the state which first set these standards for a dangerousness-based approach to commitment, Washington D.C., in fact, first outlined the parameters for commitment based on dangerousness and "grave disability" (a kind of dangerousness), though the district did not outline the parameters of these terms (Testa and West, 2010). The LPS law is therefore, often credited as the first law to systematically outline and develop a dangerousness-based approach to involuntary commitment.

Constructing the Mental State Asylum and Mental Patient in California

California has a long history of mass involuntary or indefinite commitment in facilities that functioned for both treatment and detainment. According to census data from the 1870s to 1920s, California committed more people to state mental asylums than any other state in the nation (Fox 1979, 18). Writing on the history of commitments, Richard W. Fox explains that while California state asylums attempted to model care after Eastern US "moral treatment" ideologies,[9] such efforts failed in large part because California state asylums at the time were not built *just* for the treatment of mental disorders. Rather, asylums were understood from the outset as detention facilities. Fox argues: "In California, 'custody' was paramount from the start" (ibid). Indeed, psychiatrist and historian, Joel Braslow (1997) traces the history of state mental asylums in California back to the *Euphemia,* a ship used by the city of San Francisco during the Gold Rush to "incarcerate the city's burgeoning population of criminals and madmen" (15). To remedy this ad hoc form of containment, only three years after achieving statehood, Californians built their first state asylum in 1853 and a second in 1875 (ibid).[10] The shared custodial responsibility for those considered "deviant" and those considered ill, would dominate debate and legislation around mental health asylums in the decades to come. Scattershot and contradictory efforts to mitigate such custodial responsibility in state asylums would serve as the grounds upon which cyclical and inconsistent access to care in California began.

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[9] And this is reflected in the Kirkbride architectural style that encourages patients to embody moral uprightness that one of the first state asylums in California, Napa State, followed.

[10] Both of these institutions, Stockton and Napa, were built via land-grants from colonial settlers. The land of these institutions previously operated as "rancheros" that were known to make use of indigenous labor, often involuntary or underpaid (See for instance: Hackel 1997)

In the late 19th century, commitment procedures varied across state but generally included these same procedures: First, a petition for the commitment of a person considered “insane” is filed. Medical doctors, police officers, and other public servants and also relatives, friends and employers could submit a petition. Once the petition was filed, the person in question was incarcerated in a jail or hospital facility while they awaited evaluation by two court-appointed physicians and then received a hearing. In general, most commitment petitions were approved and patients were committed (Fox 1979; Braslow 1997, 17). The relative ease by which someone could be committed in California was not without its critics at the time. Fox (1979) notes the prevalence of public suspicion citing a report from Napa State Hospital trustees in 1892 warning “that any ‘destitute and friendless’ person with ‘strong eccentricities; was liable to be ‘hurried away, railroad speed, to an insane asylum” (51).

In the decades that followed and well into the first half of the twentieth century, overcrowding of state asylums became a chief concern. Some blamed California’s Gold Rush culture, with all its promise and disappointment, a sure cause of insanity. Others considered the liberal approach judges took to commitment procedures. By the turn of the century another explanation saw the overcrowding as a reflection of the moral and righteously charitable culture in California which attached many people who struggled to survive in other parts of the country and needed asylum care (Fox 1979). Other causes may be found, however, in examining the patient population itself. From this perspective, while gender certainly influenced aspects of involuntary confinement (Braslow 1997), class discrimination and anti-immigrant sentiment combined with strict moral sensibilities (that reified white,[11] middle-class culture) were notable contributors "railroad" process to mental asylums.

In a case-study of commitments in San Francisco from 1906-1929, Fox noted several key characteristics about the people deemed insane and subsequently committed. Chief among them were class and relationship status, where "blue-collar" and unmarried or widowed San Franciscans were more likely to be committed (1979, 105). Often these commitments had little to do with mental health. When breaking down the reported behavior that indicated "insanity" in commitment documents from the period, Fox found that a quarter of the behavior cited under "facts indicating insanity" was "immoral behavior—the nonobservance of well-articulated canons of morality" such as drug use, "sexual excess" or "vile language" (ibid 142-143). Further examining these citations, Fox concludes: "Only 20 percent of the characteristics clearly indicated a serious disability and only 11 percent suggested the clear possibility of an incapacitating disturbance" (144),[12] suggesting that asylums continued into the 20th century to serve not only as treatment centers but as carceral facilities for those considered deviant or unwanted in their communities, but who had, in fact, committed no crimes.

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[11] It is important to note that "white" is a shifting population category then and now. In the historical records examined by Fox "foreign-born" include Irish and Italian as well as other immigrant populations, however growing Anti-Asian sentiment and eventually the systematic targeting of the small population of Black Californian's becomes evident in both the historical and demographic records to the degree they are available, especially when considering the geographic location of a given state hospital. So, while hospitals like Stockton (of which Stark and Braslow 2005 write) document physical interventions on predominantly white women, hospital records in Norwalk in Southern California show a disproportionate targeting of Mexican women for interventions like sterilization (Stern, 2005).

[12] After immoral behavior, irrational beliefs including delusions of persecution or grandeur and auditory hallucinations comprised 21 percent of the committed population, followed by "organic disability or affliction" (including cognitive impairments caused by syphilis and inability to care for self) at 20 percent of the population, "possibly disabling" characteristics like wandering, refusing to eat or suicidal inclination at 11 percent, threats to people or property at 9 percent (Fox notes that a third of these threats were directed at official personnel including policemen, doctors and nurses), Nervous or depressive symptoms at 7 percent of the population and finally religious delusions at 6 percent (ibid).

While a wide-swath of people in California of diverse background were subject to commitment petitions, Fox notes that that police were twice as likely to petition for the commitment of "foreign-born individuals" as they were "native born." While just under half of the entire state asylum population at the time were "foreign-born" (48%), more than 60% of "foreign-born" patients had been hospitalized by virtue of police petition (ibid, 87). After discounting familial and work status as possible explainers for this phenomenon, Fox notes that a great deal of petitions against the "foreign-born" cited "irrational" behavior and concludes that cultural difference in what was perceived as irrational public behavior was at the root.

In the same period Fox analyzes, California was home to ongoing anti-indigenous efforts and a growing anti-Japanese movement, institutionalized by laws which prohibited land ownership and which—growing from previous anti-immigrant acts like the Chinese Exclusion act—influenced the racial guidelines and exclusionary politics of the Anti-Immigrant Act of 1924 (Daniels 1978; Ngai 1999).[13] During this period and before, racial resentment and anti-immigrant sentiment especially had extended well beyond the policing of public behavior and into the administration of the asylums themselves. In 1897, for instance, the California State Commission in Lunacy sought to centralize control over state asylums not only to manage costs, but also "to relieve the taxpayers of this State from the burden of caring for so many aliens, the majority of whom are not taxpayers and have paid nothing toward the support of the State government (State Commission in Lunacy 1898, as quoted in Bardach 1972).[14]

This move to decrease the state asylum population by targeting "alien" patients was one strategy in a long line of legal and political efforts by medical administrators and legislators to

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[14] The late 18th and early 19th centuries were also marked by a history of anti-indigenous policies including "Indiana Boarding Schools." The last of these was built in Riverside California in 1902 (See for instance: Ahmed 2017).

prevent overcrowding in asylums that—by and large—failed.[15] Over the late 19th and early 20th century, alongside a continuously swelling state asylum population grew increasingly louder and well-documented resentment among medical professionals who saw the blanket carceral function of their facilities as an obstacle to the legitimization of their medical practice.[16] While the State Commission in Lunacy began targeting the "aliens" among the patient population, the California Medical Society, the State Board of Health, and other vested members of the medical community launched a successful campaign that culminated in the passage of the "Lunacy Law." This law would end court hearings and the requirement that a judge oversee commitment procedures. Instead, two physicians could examine a patient for commitment without disclosing the purpose of the examination to the patient and determine whether they should be hospitalized (Fox 1979, 53). In 1901, the California Supreme Court declared the law unconstitutional, concluding "an order for commitment of a person to an insane hospital is essentially a judgment by which he is deprived of his liberty" (ibid, 54). With that, jurisdiction over commitments was returned to judges and legal proceedings resumed and the role of due process in involuntary mental healthcare practice was cemented.

The "Lunacy Law" and the judgement against it garnered national attention by the medical public and highlighted a dynamic tension at the heart of commitment procedures: the sovereignty of the person deemed "insane" under a constitutional/legal model versus the

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[15] In 1885, for instance, the state passed the "Act to Prevent the Overcrowding of State Asylums" (Fox 1979, 43) which placed responsibility on state hospital clinicians to release those patients who clinicians believed were improperly committed and return said patients back to the county from which they had been committed at the county's expense.

[16] "That there are many persons unjustly pronounced to be insane. . . and subsequently committed by the courts. . . does not admit of question; and just so long as no vigorous measures are taken to prevent such a course of action, the hospitals of the state will continue to be the receptacle for all forms of human wreckage, regardless of law and justice. It is this excess of population, improperly committed and illegally detained, which fills to overflowing the wards of these institutions, interfering sadly with their legitimate work and mission. (Dr. J. A. Crane 1901 as quoted in Fox 1979, 41).

patient's need for care under a medical model. Further, the ruling highlighted a discomfort many medical practitioners faced in enacting care, which positioned them in adversarial relation to their patient. "The insane can never receive the kind of care and treatment accorded to other sick persons as long as the laws define them as a class requiring 'commitment' under the same procedure as a criminal receives under trial," declared New York's Charity Organization Society in reaction to the California court's decision," the accused one must be convicted (of being sick) before he can receive the healing influences of skilled treatment and curative environments (as quoted in Fox 1979, 55). In response the medical community turned its attention away from commitment procedures themselves and toward preventative and community-based measures while state asylum populations continued to grow.[17]

To work around the constitutional limitations posed on the medical community, several new initiatives that followed the letter of the court decision but nevertheless impacted the liberty of a great deal of people committed to California's asylums were put in place. These efforts included deportation, probation, and parole initiatives. Though, according to Fox, the policies that effected the state asylum practices the most were a eugenicist campaign of "asexualization" or "sterilization" in the name of preventative "mental hygiene" and a public campaign for the construction of "urban psychopathic wards" (1979, 27). Through the early 1900s and into the mid-century, California ran the nation's largest "asexualization" program, performing more than 80% of all state hospital patient sterilizations in the United States in 1922 (Braslow 1997, 56; Bardach 1977). While the sterilization campaign grew, those in the medical community nevertheless remained increasingly frustrated by the constitutional restraints placed on them through court oversight of civil commitment procedures and hospital overcrowding, sentiments

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[17] In 1912, state officials reported hospital wards holding three times their designed capacity (Fox 1979, 26).

that, at least in part, formed a growing call for mental health facilities in the city's urban centers (Fox 1979). More than stemming the state asylum population, "urban psychopathic centers" served in some measure as a means to legitimize medical care for "insanity"—a term in California that encompassed a broad range of social and cultural assessments of behavior—and medical control over mental healthcare.

Temporary voluntary and involuntary care in urban treatment centers promised a potential solution to the overcrowding and funding concerns in state asylums: if urban centers took less serious or acute or even the "deviant" but not "insane" cases, then those who were truly sick could be committed to an asylum. Additionally, the temporary involuntary commitment in urban psychopathic wards offered a means for skirting around the legal complications and constitutional violations indefinite commitment may have posed. Finally, the treatment of people for mental disorders in urban cities, would bring increasing attention to the public about mental healthcare. In 1902, the State Commission in Lunacy proposed the construction of small hospitals for mental healthcare in the state's largest cities, including San Francisco, Oakland, and Los Angeles (Fox 1979, 17-32). Meanwhile, several new state asylums were built, including the Metropolitan State hospital to serve Los Angeles and surrounding areas in 1913 (Braslow 1997, 22).

While the steady construction and operation of urban psychopathic wards in city centers were successful in broadening access to and public awareness of mental healthcare and mental health expertise, their reliance on involuntary and temporary treatment models failed to provide consistent care for those who were not sent on to state hospitals. Indeed, Fox (1979) argues that these centers did little more than temporarily detain "deviant" people who had not committed crimes and, for those who were ill, could only focus on those tasks which could be accomplished during temporary treatment; tasks like diagnosis as opposed to sustained, consistent treatment (76). Patients began cycling through such centers in states of crisis and the patient population in state asylums continued to grow, increasing “more than fivefold from 6, 864 to 36, 403” between 1910 and 1955 (Braslow 1997, 21).

Meanwhile, efforts to manage due process in the involuntary commitment of patients resulted in new compromises. In Los Angeles, for instance, the Superior court established an in-hospital court system that catered specifically to matters pertaining to mental health law. The Lunacy Division of the Los Angeles Superior Court operated on-site at Los Angeles County General Hospital in conjunction with the hospitals urban psychopathic department until the late 1960s (Mental Health Department, LA Superior Court, 2013). In 1922, the cultural associations between “insanity,” “deviance,” and “criminality” were formalized when the State Commission in Lunacy was dissolved and the jurisdiction over mental healthcare was consolidated under the Department of Institutions which oversaw both state prisons, state asylums and smaller clinical facilities until 1945. (Bardach 1972, 77). In the Post War Era, changing sentiments about mental health care and a growing prison population necessitated the dissolution of the Department of Institutions and the separate Departments of Corrections and Mental Hygiene were established (Bardach 1977, 79).

Cycling Patients and the Federalization of Community-Based Care

In 1939, toward the end of the Department of Institutions’ operation, in the spirit of “breaking down the walls between the hospital and the community,” the Department instituted an extramural program for patients deemed eligible for conditional, supervised release. The first such program in the nation, it was credited with mitigating the rise in the asylum patient population during World War II (Bardach 1972, 93). While according to Bardach, the Department of Institutions and later the Department of Mental Hygiene would face an uphill battle in continuing to breakdown such walls between “hospital” and “community,” in Los Angeles, the circulation of patients between hospital and community had become a documented phenomenon and problem. In this section, I explore initial efforts to decentralize mental healthcare and the demographic inequalities that persisted through this effort as patients began cycling through systems of care more rapidly.

While in the northern part of the state patients were committed to hospitals with frequency, Los Angeles, where access to state asylums was limited, became the only county to institute a psychopathic parole office, overseeing an average of 550 “psychopathic court wards” on “County Farms” (Chappel, 1928). In the late 1930s, the psychopathic probation department oversaw between approximately 3,400 and 3,900 cases (LA County Psychopathic Probation Department Annual Report, 1938, 1939). These cases increased during the war period. Facing a shortage of facilities and personnel due to war and noting the limits of temporary care offered in the LAC General Hospital, the Psychopathic Probation Department experimented with group-therapy, shock treatments and wrote optimistically about public education on mental health (LA County Psychopathic Probation Department 1944, 1945). Still, the lack of hospital facilities remained a concern as the psychopathic probation population continued to grow (LA County Psychopathic Probation Department Annual Report 1946, 1947). Patients seemed to cycle between temporary treatment, leading to frustration among clinicians. Dorothy Spencer, a nurse in Pasadena wrote to Governor Earl Warren in 1949. After extensive treatment, Ms. Spencer noticed, several cases “have returned to us again for further treatment.” She continued:

> Some of these patients remain out for a considerable time while some return after a brief period. In some instances, the patient does not return to us but moved into another

> hospital, thereby hoping for better results. A few patients too with whom I have come in contact with, have been to several institutions previously. . . What I am trying to convey is that so many mental cases are just going round the sanitariums and mental hospital in circles. . . . I often wonder, when patients go, how effective treatment has really been.

Foreshadowing concerns of contemporary nurses like David and Tami in the 2010s, Ms. Spencer points to a frustrating phenomenon: returning patients and patients "going round. . . in circles." Despite a large program of probation overseeing many patients, despite conversations with patients themselves, Ms. Spencer was left to wonder what happens once patients leave the institution, why? The events which occurred beyond the institution where she worked remained a blind-spot. Perhaps inspired by growing calls nationwide for community care, she called on the governor for better follow-up care.

In the wake of WWII, the federal government took an unprecedented interest in the formulation, regulation, and implementation of healthcare policy, including the passage of the Mental Health Act in 1946, which established the National Institute of Mental Health (NIMH) (Grob 1991, 1994). In addition to providing funding for research on mental healthcare and diagnosis, the NIMH worked to "redefine mental healthcare in public health terms" and championed a new system of community clinics that would work in both preventative and therapeutic capacities to, ultimately, replace the asylum system (Grob 1994, 481). Federal oversight, NIMH administrators hoped, would create a national standard for mental healthcare regardless of state ideologies of such care. The establishment of the NIMH and the initial implementation of community-based projects served to popularize the notion of mental healthcare in local clinical contexts, not only for the seriously mentally ill, but also for people "experiencing distress of all sorts" (ibid, 482; Starks and Braslow 2005).

As public interest in mental healthcare grew, factions were established.[18,19] In California, especially Southern California, extreme anti-mental healthcare sentiments rose alongside the anti-communist and libertarian leagues like the John Birch Society (Bardach 1972, 83 n11). While the more radical among the right-leaning in California grew increasingly suspicious of institutionalized care at state, community and federal levels, moderate conservatives accepted the legitimacy of mental health care but resisted federal and state spending for such mental health care facilities. Meanwhile statewide groups like the California Association for Mental Health (CAMH) grew a membership of approximately 28,000 alongside smaller, local community organizations and, together, led vocal and energetic public support campaigns for more and improved systems of mental healthcare in California (Bardach 1972, 32). As will become clear, the simultaneous call for more and better mental healthcare and also for the complete dismantling of the state asylum system in the name of patient's rights or economic efficiency reflect public political antagonism and agonism that would lead to compromises in funding and legislation in the reformation of commitment laws in the decades to follow.

Despite opposition, California legislation passed the Short-Doyle Act in 1957, promising a 50/50 state-county funding program for community mental health clinics to be administered at the local level, bolstering federal funding in alignment with NIMH goals. Funding for most community based mental health programs across the nation gradually shifted from state to

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[18] As is often cited in Deinstitutionalization literature, depictions of overcrowded, dangerously run asylums like those in Albert Deutsch's critical exposé, The Shame of the States (1948), drew attention to the lack of regulation and the broad scope of psychiatric power in state-run asylums and inspired public outcry against institutionalization from those seeking more humane mental healthcare and those who were deeply critical of such care.

[19] Meanwhile, the Alaska Mental Health Enabling Act of 1956, which allowed for the construction of hospitals and community clinics on federally granted land in Alaska and ended the transportation of patients to asylums in Oregon sparked fear amongst the public, with some—citing the proximity of Alaska to Russia—saw the federal land grant as the rise of "Siberia, USA" and the new hospitals as potential political concentration camps for all those who opposed communism (Hartley 1961, 271). Many on the far-right feared community clinics would become the means for the State to ship Californian's off to Alaska (Bardach 1972, 83).

federal responsibility as the NIMH continued to push for a national standard for community care (Grob 1994). In the decades to come this funding, and indeed the local funding for the Short-Doyle program would become vulnerable to conservative and neoliberal agendas in the late 60s and early 70s that championed individual responsibility for self-management and care. For the time being, however, federal support remained and, in 1963, President Kennedy turned his focus to mental disability *and* mental healthcare and pushed Congress to pass the Community Mental Health Act, which bolstered support for the construction of comprehensive community clinics to provide inpatient, outpatient, emergency, services, partial hospitalizations and consultation or education programs nationwide.[20]

By the mid-1960s, almost a decade since implementation, Short-Doyle institutions were generally well-received by the public and achieved a great deal of loyalty from staff despite the lower pay such public institutions offered (Bardach 1972, 82). While some administrators feared intervention at the state level from the Department of Mental Hygiene (an organization that was generally distrusted), control of Short-Doyle programs remained largely in the hands of the respective counties in which they operated (ibid). In 1966, 115, 000 people received services from Short-Doyle community-based programs with 10% of the Short-Doyle population inpatient (Jacobs 1999; 18; cf. Bardach 1972, 23). Yet, during the same year, 28,834 patients (60% of whom were first-time patients) were admitted on indefinite commitments to state hospitals (ibid). The efficacy of community-based care for those most in need was under critique, a common assumption being that Short-Doyle treated higher SES populations with less serious, easier to treat mental disorders while harder cases were usually transferred to state hospitals involuntarily

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[20] With the increasing use of psychopharmaceuticals, many believed this would end the need for state-run asylums (cf. Grob 1991, 1994; Starks and Braslow 2005). Yet, there remained a deep suspicion even among major governmental agencies at the time about the real efficacy of such treatment and its effects on the liberty of patients who took such medications (Ben-Moshe 2020, loc.1435).

(Bardach 1972, 23). Meanwhile, demographic data on patient populations though, again limited, were becoming available. In 1966, A one-day census of hospital facilities across the state, found that the Black population was overrepresented among those receiving inpatient care, comprising about 33% of the hospital resident population, a number--strikingly similar to rates of involuntary hospitalization and incarceration today—which reflects the shifting priorities of diagnosis and treatment (particularly of schizophrenia) among clinicians in response to the civil rights movements of the time (Metzl 2009).

The overall consensus among historians on the efficacy of Short-Doyle in effectively administering efficient and necessary care, especially for those with serious mental disorders remains mixed, especially when considering emerging economic interests (public, private, state, county and federal) and the way administrators at each level imagined what the "community" in community-care could be (compare: Bardach 1972; Grob 1991, 1994). While leadership at a federal level imagined involved community and familial care, for instance, historian Gerald Grob (1994) points to instances like the 1960 national census data on state asylum care There, data suggested that 48% of the population were unmarried, 12% were widowed, and 13% were either divorced or separated (1994, 487-488)[21] with a community-based care model centered around the imaginary of a white middle-class nuclear family or similar family-network of support (as opposed to other models of kinship including fictive kinship networks), the "community" in "community-based care" seemed largely imagined. Still, legislative focus remained primarily on ending or minimizing the role of state hospital care in the US and in California, in particular.

Passing the Lanterman Petris Short Act

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[21] Statistics which mirror the analysis Fox completed of commitments in San Francisco in the early 19th century.

As is clear in the subsection above, by the time the Subcommittee on Mental Health Services began considering the reformation of mental healthcare in California in 1965, diverse and divergent publics invested in the shape of mental healthcare had emerged across the state. These publics included medical and legal professionals, former and current patients, and variously invested members of the public at large—all with different articulations of what mental illness was and how/if it should be managed. The uneven distribution of state hospital and psychiatric resources influenced how these publics understood mental healthcare, how patients accessed or were committed into such care, and how medical staff carried out and understood the labor of such care, it's purpose and value. Meanwhile, sociological research and critique of the mental healthcare system, and mental illness itself, was developing in California through the works and guidance of Erving Goffman (1961) and Thomas Scheff (1966).

Building off the momentum of the Subcommittee's successful reformation of services for the mentally disabled,[22] with the establishment of county-based regional centers, Jerome Waldie and his assistant Arthur Bolton set their sights on the treatment of mental illness in California. While surveying members of the public involved in their efforts at reform for care of the mentally disabled, Bolton's attention was drawn to works by Dorothy Miller (a student of Erving Goffman and an indigenous rights activist) and William Austin Wilde (a student of Thomas Scheff) these studies highlighted the cursory manner in which involuntary commitment procedures and psychiatric evaluations took place and convinced Bolton and Waldie to turn their attention to involuntary care procedures (Bardach 1972, 101-2). While the surveys returned little concern with civil commitment procedures and greater attention to the state of children's mental

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[22] According to an oral history interview between Bolton and Allen, Shea and Associates, after completed a study for United Way in the early 1960s on care for the mentally disabled and releasing a report, Bolton was invited to Washington D.C. and his research there informed the President Kennedy's Community Mental Health Act! (Allen, Shea and Associates, 2014).

hospitals (following a campaign by CAMH) Waldie and Bolton determined they had found their cause. According to Bardach, the men saw their role and the role of state legislature to include a responsibility "to lead public opinion as well as follow it (ibid)."

The Subcommittee contracted out a series of surveys on the current resident psychiatric population (estimated at 40,000 people) and of commitment courts to the Social Psychiatry Research Associates of San Francisco, a private research firm run by Dorothy Miller. Funded by the NIMH ,the firm defined itself as "a group of researchers . . . engaged in a series of social surveys generally focused on the community careers of persons labeled as deviant" (as quoted in Bardach 1972, 106-7). Alongside these surveys, the subcommittee carried out public hearings, interviews with medical and legal professionals, as well as people connected to the mental healthcare system through voluntary organizations (Subcommittee on Mental Health Services, 3). They administered questionnaires to 320 public and private mental health facilities, to nearly 5,000 patients, and to 40 commitment courts in the state's most populous counties. These questionnaires and interviews were combined with site-visits (ibid). This data formed the basis, along with "relevant legal and mental health research and literature" the basis for "The Dilemma Report" (ibid).

Drawing heavily on burgeoning "anti-psychiatry" literature[23, 24] the report draws attention not only to the dilemma at the heart of mental commitments as they were currently practiced in California—the negotiation between public safety and individual health—but the way this dilemma is manifested through social (i.e. "middle-class" [ibid, 35]) and medical definitions of

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[23] I use this term somewhat carefully allowing for the wide variety of approaches to mental illness represented in this literature and the major shift the anti-psychiatry movement would take in decades to come (See for instance: Sedgwick (2015 [1982]).

[24] Goffman's *Asylums* (1961) and *Stigma* (1963), Laing and Esterson's *Sanity, Madness, and the Family,* and Thomas Scheff's *Being Mentally Ill* (1966) (of which the committee must have been given an advanced copy)

mental illness and mental health. The report also concerned itself with the stigma attached to diagnoses including the associations of mental illness with dangerousness. Even while working against popular assumptions about mental health, the report made several logical arguments that ultimately helped to draw out a program of involuntary mental healthcare while voluntary, community-based care was progressively defunded.

Drawing on the involuntary commitment laws in California at the time through which a person could be committed for care either because they were deemed mentally ill and in need of treatment or because they represented a danger to persons or property, the report framed a "basic dilemma" for state legislators:

> The basic dilemma in the commitment process stems from the wedding of treatment and custody objectives in a single system. A major reason for this fault seems to lie in equating mental illness with danger.
>
> The non-descriptive term ' mental illness' not only serves to group a variety of dissimilar problems into a single medical mold, but it also seems to carry a connotation of dangerousness.
>
> For hundreds of years, people have equated mental disorders and violent behavior. It is true that <u>some people</u> with mental disorders may be dangerous, but the stereotyped view may also be dangerous, but the stereotyped view is that mentally ill people are uncontrolled ' raving lunatics'. If this assumption were true, a finding of 'mentally ill' would be equivalent to a finding of 'dangerous.' If this assumption were true, one could find no fault with a court system that replaces legal proof of danger with a diagnosis of 'mentally ill' for the purpose of removing dangerous people from the community. If this assumption were true, one could find no fault with a custodial hospital system for all those labeled as 'mentally ill.' (ibid, 15-16).

The report continues on to mention that nine out of ten committed psychiatric patients were classified as non-dangerous (ibid, 19). Yet the report also sought to reach an audience not yet prepared to accept the possibility of danger still represented at least culturally by those deemed "insane," walking a very thin political line.

"The Dilemma Report" works to recognize social function of diagnoses of mental illness along "middle class" standards, the attendant stigma of such diagnosis and the disproportionate association of danger with mental illness. Yet, this is achieved largely by contrasting such diagnoses with medical diagnoses as though biomedical diagnoses were not also social, variable, and subject to the biases of medical doctors (cf. Sedgwick 2015[1982]). Along these same lines, the report does little to define dangerousness beyond acknowledging danger to self or danger to others in the form of "threat." While acknowledging the unpredictability of danger, the report does not recognize the cultural variability of perceiving, recognizing and containing danger (ibid, 143). This is not to argue that a physical harm to oneself or another is not dangerous, only that the range of dangers and risks posed to a community (both individual and collective) are variable and variably perceived and accepted by the public at large (i.e., driving in a car, smoking a cigarette, not wearing a mask, refusing vaccines, etc.). Further, as evidenced by the long history of commitment in California, many of these dangers were perceived along racial and class lines. Finally, the report operates at least initially on the assumption that custody is a "faultless" manner of preventing or containing danger." Later, the report qualifies this noting that: "Preventative jailing is a dangerous technique in a free society. Even a little is probably too much in a nation which prides itself on freedom of the individual. . . In short, when we deprive a man of freedom, we must be as certain as human mind and institution allow that we act on proof that we are no longer safe with him among us" (ibid, 145). These taken-for-granted assumptions of danger, public safety, and the operation of custody in preventing one and assuring the other would lead to significant concessions later in the long amendment process of the Lanterman Petris Short Act.

Not only a “basic dilemma,” the joint custodial and treatment functions of the current commitment system represented a “basic difficulty” for state legislature (ibid, 8). In the process of elaborating this basic difficulty a third agent emerges in the dilemma: the civil liberties of the patient. “The Dilemma Report” compares two approaches to civil commitment reform in recent years: New York where the medical imperative to treat patients without legal delay led to a system of commitment with no legal oversight and Washington DC where the legal imperative to protect due process of the law and patient civil liberties had led to a commitment proceeding overseen by courts with representative counsel (ibid, 7). This was yet another “impossible dilemma” (or an aspect of the same, basic dilemma). While the basic dilemma, impossible dilemma, and basic difficulty of the current commitment system suggest a great deal of nuance to the understanding and reformation of the commitment system at the time, the authors reduce this understanding in the following pages: “The commitment court can be seen in two ways. Viewed the first way, it provides a legal process for the removal of dangerous persons from the community confined to treatment facilities…Viewed the second way, the commitment courts provide a means of securing professional help for the mentally disordered who will not accept treatment” (ibid, 8-9). The report concludes its first chapter with the proposal of two systems, one for the containment of those determined dangerous with full due process of the law and a voluntary system for those diagnosed with mental illnesses in need of care, seemingly excluding those who may need care but refuse it. These proposals are elaborated further in the concluding chapters of the report: “A proposed system for citizens[25] with mental disorders” and “a proposed system for mentally disordered persons who are criminal offenders.”[26]

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[25] Note the careful use of the term “citizen” here.

[26] It is interesting to see so little attention to the nature of criminality in this report given the research groups critical interest in “deviance.”. Perhaps it comes out of a desire to clearly distinguish mental disorder from criminality. Perhaps, too, it predicts the social changes to come. While imprisonment rates temporarily dropped through the mid-

For citizens with mental disorders, along with a proposal to "open" all state facilities following models of treatment in Italy and an expansion of social services in the community including supervision for those in need by a division of protective social services, "The Dilemma Report" proposed that Community Emergency Service Units (ESUs) be developed. These ESUs would operate primarily at a voluntary capacity and provide medical, psychological, social and legal evaluations and short-term emergency care for their clientele. If necessary, ESU administrators could involuntarily detain a patient for 72-hours if necessary to complete evaluations and treatments. If necessary, the ESU could place a citizen with a confirmed mental disorder in a state hospital or other crisis facility for no longer than 14-days under four conditions: 1) an affirmation from a personal physician or ESU affiliate that the person is "gravely disabled, or exhibits such destructive behavior that he appears to be an immediate threat to other persons, and has refused to accept treatment on a voluntary basis;" 2) After evaluation by ESU staff it is agreed that all alternatives to involuntary treatment are no longer possible; 3) the facility to which the patient is transferred is equipped to provide extended treatment; 4) a physician at the new facility accepts responsibility for treatment (ibid 88-89). The patient must be informed of the hold immediately, both verbally and in writing. If the patient, a relative or friend contests the hold at any time, the hospital must inform the nearest superior court and a hearing must be fixed within four days. These conditions and the limit of involuntary commitment to no longer than 17-days (an initial 72-hour hold plus a 14-day hold) served as another grounds for debate—along with the merit and financing of ESUs-- in the writing and amendment of what would become the LPS act.

1970s, they dramatically increased beginning in 1980 along with a general cultural preoccupation with "crime." Some comparative data: In 1960, 21, 660 people were incarcerated; in 1970, 25,033; in 1975, 17, 296; in 1980, 23, 264; and in 1985, 48, 326 people were incarcerated (the increase in the rate of incarceration in the 1980s dramatically outpaced the rate of population growth at the time) (Langen et. al 1988).

For “mentally disordered prisoners who are criminal offenders” the proposed interventions are premised first on guaranteeing public safety and then treatment for those “who are criminal offenders under current law” (ibid, 107). The deliberation of confinement for those deemed “criminal” should, according to the report be processed through California’s criminal courts. Here, the authors make a delineation between mentally disordered behavior which may be perceived as criminal, perhaps recognizing a tendency among law enforcement to criminalize mental disorders, suggesting that the courts are well-equipped to “reroute some people, perceived as criminals by law enforcement officers, who need treatment rather than confinement” (ibid, 106). The report proposes to either improve facilities for the confinement of “criminal mentally ill persons” or give court officials “some practical alternatives in dealing with mentally ill persons which are not fully spelled out in current law.” The remaining chapter divides cases involving “criminal mentally ill persons” into two categories: those who are not guilty by reason of insanity and those who are deemed incompetent to stand trial by virtue of their mental illness. Specific court procedures and clinical oversight were outlined by both and while these recommendations were not considered by the legislature during the passing of LPS which focused solely on civil commitment, they were largely enacted in ensuing reformation of competency laws.

In Los Angeles, following LPS a separate mental health court was established that oversaw all cases having to do with mental disorders from civil commitment hearings, to competency to stand trial, to not guilty by reason of insanity cases and, finally, the guardianship of those deemed gravely disabled. Today, many research interlocutors in the court note that they see many patients in both “sides” of the court. Depending on whether or not they were arrested or transferred to a hospital for involuntary commitment, people with serious mental disorders may find their way to the mental health court either in competency cases or in civil hearings to contest their commitments.

Finally, the report elaborated recommendations for both a definition of “grave disability” and the person’s identified as such. A gravely disabled person is defined as one who is “incapable of carrying on transactions necessary to survival and otherwise providing for such basic needs as food, clothing, and shelter” (ibid, 114, 133). The proposal suggests that this definition be the standard by which judges grant guardianship. After investigation by an ESU “investigation section” which would provide a report to the court and a recommendation (or not) for guardianship –by either a “personal surrogate” or “public guardian” (a public servant of either the State or County) or a private guardian. Under guardianship, the Report recommended that the court may decide the extent of legal disabilities based on the individual case including the right to marry, vote, and work (ibid, 135). The report recommended that a person under legal guardianship could contest their guardianship once every six months (ibid). As previously mentioned, the notion and definition of grave disability became a central focus for medical professionals during the process of writing and amending what would become the Lanterman-Petris-Short Act.

The Dilemma Report received sensational media attention but its reception among the medical, legal, and legislative communities was decidedly mixed. While medical administrators were concerned by the limited amount of time for involuntary commitment (Bardach 1972, 111-112), the ACLU was concerned by the potential for clinic administrators to “play yo-yo” with patients, releasing them after fourteen days only to detain and recommit patients immediately after (ibid, 115). The DMH, meanwhile, offered a mixed response noting a potential bias in the report against the judiciary and psychiatrists. Meanwhile Short-Doyle administrators objected to the proposal that ESUs be established and operate as the primary source for mental health crises evaluations and triage. The administrators believed that funding for ESUs would supplant the work and function of local Short-Doyle programs. Before all this could be negotiated, however, Lanterman, Petris, and the legislative staff members had to get the legislative ball rolling. There was little time, political careers were at stake, and the approval of any kind of public was in delicate balance. “The ship we are trying to float,” Bolton said at the time, “can sink very easily with too much weight on one side or the other” (Bardach 1972, 118).

In November 1966, Republican Ronald Reagan was elected governor of California. Reagan came to power with a plan to decrease the state budget and a particular focus on cutting funds to state-run mental healthcare. Meanwhile, Democrat, Nicholas Petris, was elected to State Senate with his own “delicately balanced” ship to manage as a junior senator and Republican, Frank Lanterman, was appointed head of the Ways and Means Committee. Though Lanterman was a loud and long-time champion of state-funded disability and mental healthcare he would nevertheless be in charge of enacting Reagan’s controversial budget. Lanterman was pulled in two directions. As a well-respected senior assembly member, he was viewed as the best representative for the new mental health law, but his days were largely ruled by budget negotiations. Meanwhile, time was running out to write and pass a bill to reform commitment laws in California. Legislative staff drafted a bill, but after receiving a long list of critiques and feedback on medical and legal technicalities, the team withdrew the drafted bill and submitted a spot bill in its place. Its only text was its title: “The California Mental Health Act of 1967,” Assembly Bill 1220.

Over the next few weeks, Lanterman worked overtime with staff to create the amendments to AB 1220 that would serve as the primary body of the bill. As they drew closer to finalizing the text, it was Lanterman (not the many other critics of the bill) who finally put the staff's approach to dangerousness to test: did they "really mean to turn loose all those potentially assaultive and homicidal patients?" (ibid 123-124). Despite The Dilemma Report's caution against preventative custody for those deemed dangerous and the associated stigma, the staff redrafted the commitment process to allow for an additional 90 day hold for patients who "threatened, attempted, or actually inflicted physical harm upon the person of another after having been taken into custody for evaluation and treatment" (ibid). This move would lead to greater emphasis on dangerousness in the final law and in the practice of involuntary commitment in the years to come. Draft finished, Lanterman and staff had yet to leap several political hurdles: a steadily building political and public controversy over Reagan's budget and months of political and public hearings on their proposed bill.

Leveraging his popular and established career and his position on the Ways and Means Committee, Lanterman was able to wrangle minimal support from Reagan for AB 1220 and Reagan's initial impulse to cut mental health care spending was reduced to "holding the line," there would be no cuts but there would be no increases either (ibid, 118). Meanwhile, in hearings for the bill, members of the medical community raised several concerns with the new bill. With Short-Doyle funding up for renegotiation that year, administrators feared AB 1220 funding would supersede the funding for already established community programs. Clinicians feared the bill would "abrogate medical responsibility" and pushed to broaden the definition of "grave disability" to include the phrase "unable to manage his personal affairs" so that medical staff could act in the best interests of the patient (ibid, 126). Lanterman and staff dodged these requests only to face them again in later hearings. There, doctors proposed "grave disability be defined as "a condition in which a person has a pronounced disturbance in judgement, thinking, or conduct as a result of a mental disorder or impairment by chronic alcoholism" (ibid, 130). Still, Lanterman held the line at the Dilemma Report's original, limited definition. Finally, clinicians feared legal liability under the laws new court mandates. While Lanterman made concessions here, the bill nevertheless began to lose endorsements including the critical endorsement of the County Supervisors Association of California Health and Welfare Committee.

Over the next few months, in a scramble to regain support, Lanterman and his staff drafted four-sets of amendments, containing 300 amendments overall (ibid, 131). Time was running out, opposition was growing, no one outside of Sacramento was quite sure what the bill said at any given time. Despite the confusion and opposition, the bill nevertheless passed on the State Assembly Floor. Still, AB 1220 still had to face the scrutiny of the much more conservative State Senate. Unfortunately, AB 1220 was eventually handed over to the Senate's Governmental Efficiency and Economy Committee, known by many as the "graveyard of legislation" (ibid, 136). Despite a well-fought battle by Lanterman, Petris and their staff, the Committee "took the bill under submission," allowing the legislative session to end with the bill unpassed (ibid, 137). AB 1220, that easily sinkable ship seemed to have, finally, sunk.

Still, Lanterman continued on. As head of the Ways and Means Subcommittee he would oversee the review of several senate bills including one which gave more state money for Short-Doyle (Senate Bill 677). Using a legislative rider, the assembly amended SB 677 and revived the entirety of AB1220. The original author of the bill, Alan Short, was ambivalent toward AB 1220, but, facing potential obstacles to future legislative actions by Lanterman and others, nevertheless agreed to "author amendments" and the new, Lanterman-Petris-Short Act was passed quickly in the assembly. “For reasons still obscure,” Bardach writes, SB 677 was not sent to the General Efficiency and Economy Committee and was, instead, sent straight to the senate floor.

Lanterman, Petris and staff needed to rally at least one person to their side for the senate vote to pass in their favor. In their research, they found a letter of support for the change in commitment laws and an end to state mental healthcare from the conservative “Santa Ana Freedom League,” a group from Orange County that turned out to be just the right leverage point for Senator Schmitz, their representative. However, Schmitz would support the bill only if funding provisions that would assist the expansion of local mental health programs and community-based care were removed. Those provisions were removed. SB 677 was passed. By the end of this political wrangling, a great deal had changed. While involuntary commitment was limited on the whole to 17 days, extended periods of commitment for people who were “visibly dangerous” and guardianship for people who were “gravely disabled,”[27] were allowed. Patients were guaranteed the right to refuse treatment and, while ESUs had been eliminated, multidisciplinary teams of caseworkers, psychiatrists and other clinicians were given power to evaluate and offer financial assistance and mental healthcare referrals. The bill, with its new revisions, passed again through Assembly and Senate and was signed by the Governor (ibid, 140).

In the end, the Lanterman-Petris-Short Act looked something like the two separate systems initially imagined in The Dilemma Report, but the revisions—especially budgetary revisions—combined with the end of funding for community-based care at a federal level in the 1980s under Reagan’s presidency, and increased funding to state prison and county jail systems

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[27] Which managed to retain The Dilemma Report definition over the course of so many amendments and despite objections

with a growing number of beds in state hospitals dedicated strictly to forensic patients (e.g. those deemed incompetent to stand trial) left California with a mental healthcare system in pieces despite valiant efforts by many to grow and maintain effective community-based mental healthcare. In theory, there were two systems in place: a community-based voluntary system for those in need of treatment and an involuntary system for those consider dangerous to themselves, others or gravely disabled (a kind of danger to self). However, only one the latter system retained semi-consistent public funding through the decades to come.

Meanwhile, a growing organization of family members of people with mental disorders organized in California, Parents of Adult Schizophrenics (PAS) began organizing in San Mateo and eventually became part of a wider network of advocates under the National Alliance of Mental Illness (NAMI). In California, NAMI and others pointed to the obstacles imposed by the Lanterman-Petris-Short Act. If the only recourse to getting care to a patient who was refusing was to wait until the patient was dangerous or "gravely disabled" then family members were placed in a difficult bind. They would have to wait until their loved ones were so ill that they became a danger to self or others, or else neglect their loved ones until the state would recognize their "grave disability." For some, the response became to advocate for greater latitude with commitment procedures in collaboration with the medical community rather than greater funding of community-based care. This resulted in some reforms to involuntary medication administration greater use of conservatorship (guardianship) procedures to insure consistent access to care in the community, and a new law, introduced by Frank Lanterman in 1974, which allowed for "outpatient committal" (Jacobs et.al. 1999). In the days before his death, according to his secretary, Frank Lanterman reportedly stated: "I wanted the LPS Act to help the mentally ill. I never meant for it to prevent those who need care from receiving it. The law has to be changed" (Dewees 1987 as quoted in Jacobs et. al. 1999).

A "New Dilemma:" The Revolving Door in Reform

"The LPS laws are a funnel upside down, very hard to get in, easy to fall out. That's why there is a revolving door syndrome. This topsy-turvy upside down kind of theories that go on and on and we the parent suffer. We have to become liars. We have to almost criminalize our children in order to get help" - *K.P. "Mental Health Laws: Is Reform Overdue," Hearing LA County, 1998*

"The only thing good about a revolving door is that one gets to see the patient is still alive"- C.K. *Mental Health Laws: Is Reform Overdue," Hearing LA County, 1998*

In 1999, responding to growing calls for reform across the state at public, institutional and legislative levels, [28] the LPS Reform Task Force, a committee of clinicians, lawyers and administrators gathered by NAMI LA and the Southern California Psychiatry Society, released a new report: "A New Vision for Mental Health Treatment Laws." In a critical reversal, the Task Force, wrote of a "new dilemma:" "how to provide treatment to people who do not have the medical capacity to accept or access it themselves, but who live in an open community environment" (Jacobs et.al., 8). Writing against the anti-psychiatry literature that informed the first Dilemma Report, the Task Force elaborated further: "How to handle the serious, hard to reach patients—who needed treatment but did not fit the new criteria or who recycled through short term stays—became a community dilemma. For them, there was nowhere to go" (ibid, 23).

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[28] In the early 1990s, state legislators took up the call to reform the mental healthcare system yet again. Prefacing "California's Mental-Health System: A History of Neglect," Democratic Senators Diane E. Watson and Dan McCorquodale wrote:

> California's mental-health system is in very poor health indeed. Some criticize it as the poorest thing our state government does. Public mental-health care has been weakened by rounds of budget cutting. It is saddled with funding formulas that favor some counties over others. It is beset by fragmentation, muddled responsibilities, unmet needs. Across this bountiful state, mentally disabled people live on the streets or are warehoused in jails. Community mental-health services have never been adequately funded or developed in the Golden State. (Watson and McCorquodale 1991).

The Task Force made twelve recommendations. While advocating for an expansion of definitions of mental illness grounded in a biopsychiatric understanding rather than social or cultural understanding and arguing for some forms of expanded community assistance, the Task Force's recommendations for reform operated primarily on the premise that civil commitment is a necessary tool for psychiatric care. These recommendations draw heavily on literature by advocates for civil commitment (See for instance: Torrey 1997). Written under the premise that while jails and prisons are necessary but people with mental illnesses should not be among those incarcerated, the recommendations made some gestures toward patient rights as a whole. At the same time, the report emphasized *dangerousness* as a key factor in the treatment of the seriously mentally ill through summaries of local studies and in quotes excerpted from a hearing held by the LA County Board of Supervisors. Through these recommendations and reports, the Task Force advocated for a reformation of LPS laws to once again extend psychiatrists' role in enacting both the *parens patriae* power of the state (through the privileging of "medical necessity") and the police power of the state through the expansion of commitment procedures based on dangerousness.

Rather than a dilemma for legislature, this new dilemma, the Task Force writes, is one faced by "the community." While this community seems primarily representative of NAMI members, clinicians, law enforcement and legal professionals, the report does include the voices of some patients, concluding with seventeen pages of excerpted quotes from a hearing held by the "Mental Health Law: Is Reform Overdue." Among the quotes from clinicians, law enforcement, social workers and legal professionals are accounts from family members who had struggled to find care for their loved ones, lost loved ones due to violence in moments of psychosis, and who, desperately, wanted to find care for their family members. Also included are five accounts from people with diagnoses themselves. These excerpted quotes paint the picture of a community of patients who variously engage with medication but who have all been hospitalized. Two patients discuss the positive effects of medication, another notes the most beneficial treatment has been invested friends. Two patients make statements that the laws should not be reformed, noting the protection that they have received to make decisions for themselves as a result. These excerpts reflect a community largely missing in the rest of the report, or else, only gestured to with a half-page consideration of patient's rights as necessary at the end of the report. The remainder of the report focused on the large-scale cycling of patients through an underfunded mental healthcare system, emphasizing danger to the public and danger to the patients themselves along the way.

This report reflected some cultural shifts while also re-amplifying the demand among many medical professionals throughout the history of California reform for the legitimacy of psychiatric practice as a medical practice and the need for medical control over the shape and function of mental healthcare systems. The report vehemently argued against a social or cultural understanding of mental illness in favor of a biopsychiatric, reflected in their first recommendation to legally redefine mental illness to include specific disorders and "major dysfunction in the individual's behavior or personality" (7). This new definition would broadly expand the number of people to be considered for possible commitment under the LPS Act. It echoed the advocacy by Short-Doyle administrators in the 60's to include consideration of "pronounced disturbance of judgement, thinking or conduct" in the definition of "grave disability." While writing against the original Dilemma report, denying the relative social and cultural interpretations of dysfunction, the report legitimized psychiatry by paralleling the practice to biomedicine as scientific and therefore objective.[29]

In further reaction to the Dilemma Report, the Task Force Report drew on literature opposed to the anti-psychiatry movement which favored civil commitment; literature which, while noting the minimal role people with mental illnesses play in the overall violent acts committed in a society, nevertheless sensationalized the potentially violent mentally ill persons as “walking time bombs” (Torrey 1997, 44) and imagined structured environments for patients as those which include locked facilities and court-ordered community treatment (Lamb, 1999, 55).[30] While the old dilemma called upon the limitation of medical custody for the sake of community-based care, the new dilemma called upon the limits of community to advocate for increased medical control, including custody over those diagnosed with mental disorders.

The “revolving door” made an appearance throughout the text, but was given its own section immediately following the announcement of this “new dilemma” of patients who had been “recycled” through the mental health system. Here, the report relied upon an understanding of the consequences of deinstitutionalization still popular today: the release of patients led to an increase in homelessness and incarceration of those with mental illnesses. Without discussing the defunding of community treatment and the way middle-class models of community (based on the nuclear family) limited its capacity, without discussing the lack of public housing infrastructure which may lead to homelessness and the effects of homelessness on mental well-being, without

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[29] This is not to say that biomedicine does not have real and legitimate effects on a person’s health. Rather, it seeks to recognize the ways in which scientific discoveries, the questions that guide them and the interpretations of the discoveries themselves occur within a social and cultural context.

[30] Though, as will be seen, the LPS Task Force doubles down in some ways on dangerousness standards, Torrey and Lamb (a member of the LPS Task force) would later co-write a report advocating for the elimination of dangerousness standards in mental health commitment laws, noting the way these standards may be what necessitates law enforcement involvement in mental health crises (2010, 15).

discussing the rise in state funding for prisons instead of community health and mental health centers,[31] the report noted that county jails "had become de facto institutions for people who didn't succeed in the increasingly short-term hospitalization and voluntary community treatment environment" (ibid, 24; cf. Ben-Moshe 2017, 2020; Tate 1991, iii). Immediately following this observation, the report described the typical path of "revolving door patients:"

> California is still experiencing the reality of recycling patients, a costly situation both in terms of human suffering and economic impact. Typically, what happens with revolving door patients is that they stabilize during a hospital stay, but only continue their medication and outpatient therapy for a short time after discharge, if at all. Most relapses in people with mental illness who have been hospitalized occur because of medication noncompliance; noncompliance rates are significantly higher during the first few months after discharge than at any other time.

Because the report spent a great deal of time discussing "insight" into one's mental illness (cf. Gong 2017) as a necessary component for patient compliance, the above quote's focus on medication and outpatient therapy compliance can largely be understood as a result of individual failure to recognize the need for treatment and comply with a plan of care as a key component of the "revolving door" phenomenon. Another view might consider how familial and community understanding of mental health may impact insight and compliance of individual patients. Still yet another may recognize the lack of resources including public housing and hyper-policing of the homeless and people with mental illnesses that occurred in the 1990s and continues today may likewise lead to lack of compliance (See for instance: Ben-Moshe 2020).

While acknowledging the underfunding of community services and quoting some patients and family members toward the end, there was a largely institutional perspective in the

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[31] Later, the report notes a study which found that patients with schizophrenia released from involuntary commitment for no longer meeting criteria spent an average of 28 days in jail mental health treatment, while those who continued involuntary care averaged one day in jail. Indeed, the additional time in treatment may have led to more stabilization for patients and better success later on (or at the very least kept the patient detained in the hospital and thus less vulnerable to policing), but so, too, might the expansion of information about mental health via broader, accessible community networks of care as had been recommended in a 1991 statewide report (Tate 1991).

report which insisted on decontextualizing mental health services and mental healthcare from the society and culture in which they operate. The section on the "revolving door" concluded with a picture of previous mental healthcare reform that framed deinstitutionalization as a finalized process that has led to inadequate care: "A significant number of people with mental illness need more structure and support than the community service system currently provides. Instead they revolve from the hospital to the streets and to the jail. For them, we have replaced one inadequate system of care—keeping people institutionalized for long periods of time—with another inadequate system of care" (ibid, 25). Such a conclusion positioned the Task Force well for an argument in favor of increased involuntary care and commitment in mental health facilities.

The LPS Reform Task Force walked a line between recognizing the need to end indefinite involuntary commitment prior to the Deinstitutionalization Era and the need for increased intervention and longer hospitalizations for those with serious mental illnesses. As previously discussed, the Task Force made twelve recommendations, including: The expansion of conservatorship (guardianship) as a possibility for all persons involuntarily committed (not just those committed under "grave disability"); A reduction of the criterion for dangerousness down from "beyond a reasonable doubt" to "clear and convincing evidence;" An expansion of holds based on dangerousness to a possible year (under conservatorship); An expansion of community assisted treatment networks for "aftercare" and psychiatric mobile response teams of trained professionals to intervene in mental health crises; and recommendations of uniform standards and funding for mental healthcare as a form of community assistance. These recommendation limited the demands for evidence in the courtroom, expanded preventative custody for those deemed dangerous and community assistance for those who have been involuntarily committed, without also recommending the expansion of outpatient clinical resources. They elaborated funding along “community assistance” lines, which would increase state oversight and managed mental healthcare models that failed to engage the stated needs of patients as they lived and managed their well-being within these communities. These recommendations were sporadically under-funded in the years to come, leaving many still vulnerable to the revolving door.

The Revolving Door and the Black Box

By the time I began my research in 2013, with the help of funding from California’s 2004 Mental Health Services Act, many of the Task Force recommendations had been put into place. Though, community-based measures were implemented sporadically and with minimal funding throughout the state and LA County. At Los Angeles Public Hospital, under the leadership of the Psychiatric Department Chair, Francis Nowak, new emphasis had been placed on early-intervention for people experiencing psychosis that may lead to schizophrenia, building relationships between family and patients and between patients and community networks of care, with each patient receiving at least a referral to outpatient clinics upon discharge. Yet, still facing an often overwhelming number of patients and limited resources, these efforts were often inadequate. While the “revolving door” remained an existential metaphor of significant concern for many doctors and nurses in the hospital, Dr. Nowak had a slightly different perspective.

I spoke to Dr. Nowak a few days after my time spent shadowing Dr. Walsh, a day of “chaos in the ER,” when the onslaught of new patients seemed never-ending (Fieldnote One). Pointing to the census data across LA County’s three psychiatric emergency rooms, Nowak indicated that, in fact, the patient population was somewhat stable at LAPH. Clinicians in the ER tend to only remember those days when things get “hot,” he explained. It was difficult to keep a perspective that was mindful of where emergency services operated in the overall “haphazard” mental healthcare system, Dr. Nowak explained. In fact, keeping that perspective would be a big part of the work he did with the incoming resident doctors who would begin their training in the coming days. He emphasized the need to train people how to guard against the “therapeutic nihilism” that was so often the response to the number of patients who moved through the ER in crisis. I thought back to David’s “laugh to survive this place” attitude as Nowak spoke.

Abby: What are the—what are the things that you want residents to come away
from—to come away with from this program?

Dr. Nowak: For me the biggest issue is related to the idea that people get better.
I guess it’s nice that they [the residents] are actually in the VA [during rotations]
where they get an outpatient experience,
but they really get a very minimal outpatient experience within the county population
because they’re at the hospital where we don’t have outpatient mental health services
here at the hospital.
So, my big goal for them is to recognize that
despite how sick they see people when they’re in the inpatient unit,
people do get better and they need to not have this sort of nihilistic, you know, idea,
this so-called “therapeutic nihilism” that they think nobody gets better
‘cause all they see is the folks that are sick
and they see the people who are, you know, **“revolving doors.”**
They’re *not* seeing the people who ***not*** **revolving doors** and
so they assume all people never get better.
But that’s only because **that’s what’s in front of you**.
In reality, people do get better and **you’re not seeing them**
because they’re not coming back to the front door of the hospital.
So my message always is, when working with the residents and supervising, in
particularly, is to sort of let them see the long-term trajectory of these illnesses.
That, yes, they’re very severe,
but with treatment and follow-up and continuity of care
you can make a big difference in someone’s ultimate outcome.

Throughout the interview, Dr. Nowak emphasized the need to see “the bigger picture,” that, in LAPH, they were only seeing a “bad sliver” of someone’s life. It is worth noting that for Dr. Nowak, this task of recognizing the place of emergency services within the larger mental health care system is work. It requires an attitudinal and perspectival shift toward what “you’re not seeing." In the process, he elaborated the experience of seeing or encountering a "revolving door," one which is hard to ignore because it *is* "what's in front of you," even if it is only a glimpse, a "sliver" of someone's much larger life trajectory. Yet, even here, the mechanisms of the "revolving door" or the experiences of "revolving door" patients remain obscured. How or why such patients return is unclear; and yet, they remain a problem of perspective, one which keeps clinicians from seeing the much larger, more successful picture of the operation of the mental health care system at large.

No doubt, if I had asked Dr. Nowak to elaborate further on what a "revolving door" patient was, I would have received a deeper description of the cases of patients who cycle through LAPH. Dr. Nowak, a participant in much of the LPS reform discussion in the 1990s, had continued to promote research on outcomes for emergency psychiatric patients, and emphasize connections between the hospital and outpatient centers, the hospital and the community at large. In our last interview together, nearly a year later, I asked him how the hospital kept track of patients who returned. "We don't keep track of it because it's such a flexible, I mean variable thing," he explained:

> Because, think about all the different ways in which they would come back. First of all, as you know, there are three separate Psych ERs that people can show up in . . . and remember, besides those three Psych ERs, there's hospitals that take people directly. . . so it's a shame we can't figure out how many people come back to us, but I think it's sort of misleading, because it's an accident if they come back to us as opposed to a variety of other in-doors you can get back into the patient setting.

Again, Dr. Nowak attends to perspective here. The Psych ERs are places "people can *show up* in", that is places where people appear and, more importantly, they are one among many "in-doors" through which a person can enter the patient setting. There are then, a number of blind spots and gaps in ways of knowing about a patient by virtue of the way the institution sees and is able to keep track of patients. We discussed recent efforts to further unite the variety of systems which tracked patient health from the Veteran's Affairs hospitals to Department of Health Services to Department of Mental Health. Despite effort, the work to overcome HIPAA and competing public and private health services made it difficult for a united health tracking system in Los Angeles. Though a recent update allowed all DHS records to be shared across hospitals, there remained blank spots. For the psychiatrists at work, these blank spots made it difficult to determine from others' notes what kind of clinical interventions had already been made, what diagnoses the patient possibly had already been given, what hospitals they'd been to, and/or where they were if they were in the cycle of LA County's revolving doors. I told Dr. Nowak of my mapping efforts with other interviews:

> **Abby:** I've been trying to get at, a little bit—like the ways that people imagine what happens once a patient leaves the hospital.
>
> **Dr. Nowak:** Right
>
> **Abby:** Um. It's an interesting kind of blur.
>
> **Dr. Nowak:** Yes, "black box," I would say, more than a "blur."

Somewhat haunted by Dr. Nowak's words, I have continued to return to this notion of the "black box" and the "revolving door." The black box alerts us to the unexplainable or else too complicated to be explained and yet, also persists as a "thing" that's "there," a presence or force that is operation. Meanwhile, revolving doors are mechanisms that offer only glimpses of inside and outside. Designed to control the internal temperature of a space, they also control the internal temperature of a space, they also control the rate and manner in which people may enter, depending on their size, their baggage, the company they keep. A revolving door can trip a person up. It may move too quickly or else too slowly, whipping people through or else becoming stalled as too many try to enter at once. Through the revolving door, only fits and starts of the outside are allowed in. Importantly, it is not only people which enter sporadically through a revolving door, but the atmosphere that follows them. In the case of the many "revolving doors" in Los Angeles public infrastructure, this atmosphere includes political, cultural and historical ideologies of other institutions and often mooded ways of enacting and engaging such ideologies. The "revolving door" is a critical conceptual framework not only for thinking or talking about the interaction of public systems and the various ideologies that inform their operations, but also for explaining how such systems are seen. In the coming chapters, the cycling porosity of public systems will come to bear on how doctors and nursing staff negotiate and understand their roles as moral caregivers and agents of these systems, determining who is worthy of care and who is not.

Left: A palm tree stands in stark contrast against the smoke filled sky (July 2016). Right: The glare from a street light overlooking the parking lot at LAPH (August 2016)

FIELDNOTE TWO

The Night Shift: Diagnostic and Other Ambiguities

August 2016

“I am tired now. Tired a lot.” I jotted in my notebook, two weeks into night-shift fieldwork in the Psychiatric Emergency Room. The drive to the hospital, now a journey I could take almost without thinking, had been disorienting. The turns and highway exits that had once taken all my concentration were now just a series of muscle movements. Car parked, I closed my eyes for a few moments before entering the hospital. I willed myself to a minimal kind of alertness. 5:00pm, in time to observe both doctors’ and nurses’ sign off on patients during the shift change. I gripped my thermos of coffee tightly as if, somehow, the nearness of the coffee itself would be enough to get me through the night. I entered the ER through the emergency entrance, nodding to the security guard while raising my badge. David had been working as charge nurse. It had been a busy day, he told me. They began the day with 33 patients and now, though some had been discharged, there were 30 patients on the unit. A stark difference from the patient census just over a week ago.

It had only been a few days since the Sand Fire that burnt through East Los Angeles had been contained. During the height of the fire, with resources directed elsewhere, there had been few patients in the Emergency Room. Over the course of two weeks, the fire destroyed eighteen buildings and taken two lives, making it one of the deadliest fires that year. Though many miles from the fire itself, ash had rained down on my apartment in Hollywood. Smoke clouds loomed over the county, darkening the sky and turning the sun an apocalyptic red. As the fire department worked overtime, dusky days bled into nights, both haunted by the caustic smell of urban fire—burnt rubber, charred homes, scorched earth. My first experience of such a major fire, I learned to take short breaths as I moved between apartment and car, car and hospital. The looming fires had distributed my attention to crisis, which had, until then, generally been constrained to my work in the ER. I was unmoored. The lack of light, the lack of sleep, the lack of air—it all worked to keep me thoroughly unsettled.

Perhaps that was why, in the days after the fire was contained, exhaustion finally took hold. Perhaps that was also why the ER now seemed overwhelmed by patients in crisis. After hanging my bag in the break room, I returned to the desk where David was puzzling over shift assignments. They were understaffed. It seemed impossible to meet everyone's requests for time off and also keep the ER at an appropriate nurse-to-patient ratio. Still feeling foggy, I walked over to one of the patient rooms—the green room—and sat down with the nurse attendants who were supervising the space. It was hot and musty. "Clinically sweaty" I wrote, trying to name the way the smell of disinfectant and sweaty humans mingled. "Tangy." "Pungent."

In the nurses' station behind me, several day-shift nurses were working quickly to finish the tasks of their shift, delivering reports so that their patients could be transferred to other units. Dr. Harmon entered the room, commenting on the heat and the smell. She found a patient toward the back and tended to an open wound. I walked with her out of the room and joined her, Dr. Seale, and Dr. Evans who had just signed on for the night shift in the doctors' hub. On our way, we passed a patient, Stephen, who was waiting to be seen. The intake rooms already occupied, the patient remained restrained on a gurney until the doctors could see him. In the meantime, he yelled to anyone who passed by about the illegality of the situation. He should be free, he demanded. Dr. Harmon prepared the intake documents for an initial interview. After interviewing Stephen, Dr. Harmon reviewed her impression of him with me. Stephen believed he was being spied on and that his home had been infiltrated with spyware. He also had a reported history of methamphetamine use. It would be hard, Dr. Harmon explained to tell if the patient's paranoia was the result of methamphetamine use or psychosis. She began working over the patient's initial intake note while I left to observe Stephen's intake with nursing staff.

I found Isaac, the nurse tasked with Stephen's care, in the medication room. The door always locked, I knocked. He let me in and agreed that I could observe this intake. He was preparing an intermuscular injection—the standard 5-2-50 of Haldol, Ativan and Benadryl—that Dr. Harmon had just ordered for the patient. I watched as he drew out the Haldol and then pushed it into a vial of Ativan. The Ativan, he explained, was viscous and sometimes hard to pull out. It helped to mix the medications in this order. As he was doing this, I began to understand why some among the clinical staff called this shot a "cocktail." Once he was finished, he walked down the hall to the gurney. He noticed that the patient's restraints were loose and asked the EMT who was standing by to adjust them. Another nurse had also joined us as back-up while the medication was delivered. Stephen resisted. He did not want this shot. He continued to yell after it had been delivered. Isaac returned to the nurses' station and dropped the syringe in the hazardous waste box. He would wait for the medication to kick in, he told me, before moving the patient into one of the rooms.

Isaac and I parted ways for a moment and, so, I found myself waiting in the hallway with Stephen, the EMTs and a police officer who was there for another case. The officer was an older, phenotypically white man, his hair cut short, army-style. He moved in close to me, a bit too close. Stepping back, I asked him how he decided to take a person to the Psych ER or to jail. He shrugged. It depended on whether the patient had committed a crime or not. If they committed a crime and were sick, well, they would get treatment in jail from one of the jail psychiatrists. He pointed to the patient he was waiting with in the intake room. She had raised a garden tool above her head during a confrontation with a family member. That was almost a crime. It could be a crime, actually, he corrected, the threatening. The family did not want to press charges. So, he said, it depends on *if* the crime is committed and the wishes of the family. He trailed off and I noted that it looked like something he was still thinking through.

I realized Isaac had not come back because the nurses' rounds had begun. In the nurses' station, he explained Stephen would have to wait a while longer. Each day-shift nurse took a turn describing their patients and each patient's respective treatment plan while the night-shift nurses nodded along. He ran through the numbers of patients who had been admitted, transferred and discharged. Not trusting myself to get this correct in my sleepy haze, I ran over them with him again after the nurses' rounds had finished and Isaac had moved Stephen into a patient room.

David told me that the count had been off anyway. He gave me the corrected numbers: They began the day with 33 patients. Three were "discharged to self," meaning they could leave the hospital on their own. Eleven were transfers, meaning they had ended the day with twenty-five patients and with two waiting. A third patient had come in during rounds, but this patient would be part of the night-shift count. Perhaps sensing how tired I was, David made a few jokes. One of the patients had said he was "on the lam," David told me. Gesturing to his own big and tall body, David joked "I wouldn't get too far on the lamb." He told me to write this down and underline l-a-m-b. My memory of this moment now and in my typed notes is blurry, but I imagine I at least smiled.

I found my way back to the green room. In the long night-shift hours, sitting with nurses or nurse attendants at the observation desk there had become a kind of break. Alice and Lucia were sitting behind the desk. Over my time on the night-shift I had learned the pair were dear friends. They took care of each other's respective patients during breaks, but also when they were working together, each attending to the other's needs. Alice, who had immigrated from Nigeria, and Lucia, who had immigrated from Haiti, also shared a deep Christian faith. From our positions behind the observation desk, we watched as a patient danced, spinning so his hospital gown fanned out. He wore a towel tied tightly around his head, the length of it hanging down between his shoulder blades like a ponytail. As he was spinning, he said something about voodoo and Lucia shook her head. She asked him who he has love for, God or darkness. God, the patient said. "Amen," Alice and Lucia said in response.

Alice left to attend to another patient and Lucia moved over to talk to me. I was sipping coffee from my thermos and she looked displeased. I should cut back, she told me, but not cold turkey, a little less every day. I agreed with her, though admitted to myself this was unlikely. She teased me about my coffee habits until I must have blushed or looked slightly ashamed, because she then patted me on the shoulder. She was only joking, she explained. She was serious about the diet change though. It was easy to get sick on the night shift, she warned. You have to make sure you have a good diet. I nodded, admitting to myself that my diet had been bad, “mostly cheese sandwiches.” If you aren’t careful, Lucia warned, you get depressed on the night shift. She listed the risks: working all day, go home, sleep, wake up in time to get back to work. Not seeing the light of day. Being on a different routine than friends and family. As she spoke, I remembered my first night in the hospital. Lucia had insisted I take a nap in one of the patient rooms, sleeping between two other nurses on break. I thought, for sure, Lucia had read the exhaustion on my face.

I asked Lucia if I could shadow her for the night. She seemed a bit hesitant and asked if we could split the shadowing between her and Alice. Of course, I agreed. Lucia visited two of her patients, including Stephen, but neither had any requests or urgent needs. Not much was happening with her, she told me. I should go observe the next patient intake with Alice. Sensing I ought to respect this suggestion as a request for time unobserved, I made my way back into the hallway where I bumped into another nurse. We chatted for a while until I found Alice, preparing to complete the intake for a new patient. Bruce was white man in his mid-50s, white hair, balding at the crown of his head. He acted much younger than his age, I thought. It was almost like he wanted to be babied. He spoke in pleading, begging kind of way. He had been brought in by police officers as a danger to self. Alice directed him to a patient room and, as he was saying goodbye, Bruce promised he would try to stay alive because of the officers’ story. Later, he told us that the officer had told him about losing someone to suicide. Bruce commented that he had no other reason to stay alive but for that officers’ story. He showed us the card the officer had given him. Bruce would call once he was out of the hospital.

Alice moved Bruce into one of the smaller patient rooms where Stephen was now fast asleep. Lucia was already there, sitting behind the desk. A nurse attendant had collected Bruce's belongings—shoes, belt, wallet, phone—and was cataloging them before preparing them for storage. Alice went over Bruce's circumstances with him, as she tried to assess his needs. He no longer had a place to stay after a disagreement with family. He had nowhere to go and no one who cared for him now, he said, weeping slightly. Alice and Lucia took turns comforting him. He said no one loved him. They said "we love you." He said that he hated himself. They said he could not get better until he found love for himself. He commented that a friend should have let him kill himself the night before. "No, no," Alice chastised. Bruce seemed to calm himself down a bit in that moment. Alice got Bruce a dinner from the meal cart and then left to get his medications. She shook her head. The patient was a "drama queen," she joked. "Drama king," she corrected.

As Alice began to chart, she told me a little about her work. She had worked in private mental health facilities and in hospice care. The former was exhausting and burnt her out while the latter had been deeply fulfilling. As difficult and moving and as important as bringing life into the world is helping others to leave the world, she said. Alice sighed. She struggled with work in the ER, she told me. The "revolving door" wore her out. Constantly seeing the same patients cycle through, rarely seeing any improvement beyond stabilization. I asked her how she managed it, how she approached care in such a situation. "Mental illness knows no bounds," she told me. You have to come first from a place of love. Seeing the patient not as a mental illness or a patient but as a human. Then, when you are tough, when you are stern, they understand that it is out of love. She thought back on her hospice care work. She didn't think she'd stay in the psychiatric emergency room forever, necessarily, she reflected.

Alice stepped out and Lucia stepped into the nurses' station. See? She asked me. Alice had more interesting things going on. I asked her what she thought about Bruce. Perhaps, Lucia reflected, he wasn't aware of what others had been doing for him, the care they had given. That seemed like a very male thing to do. She reviewed a bit more of the patient's circumstances and confirmed her impression. I asked her if she would ever be open to an interview. Lucia tightened her lips. She was wary about being recorded, she explained. A lot of people are, she continued. Giving control of your story to someone else. You can never know someone just from one interview, she warned me, just like she could never know these patients. I told her I completely agreed. The mind is a spiritual thing, she continued. The work they do in the Psych ER is serious for that reason. The mind is spiritual and it is changing. You can never know someone. "If you think you know something, that's when you're in trouble."

July 2016

It was a quiet night, that first full-night shift. The Sand Fire had broken out only a few days earlier and, so, there weren't very many patients in the psychiatric emergency room. Only eleven. The night began with some political debate among the nurses. Unlike the attending psychiatrists who shared a commitment to voting for Hilary Clinton, there were several nurses who deeply supported Donald Trump. The debate waned as the night wore on. Soon, all the patients were asleep save one. Lucia's patient, Miranda, a very young woman was experiencing extreme hallucinations. Eventually, Alice and Lucia moved her to a quiet room so she would not disturb others. Once the unit had achieved a level of calm, Alice and a few others decorated the break room and brought in food for a small baby shower for one of the nurse attendants. Nursing staff moved in and out of the party over the night as their breaks allowed. In downtime, Eddy, a young Filipino-American nurse with broad shoulders and distinctive glasses performed a somewhat reluctant wedding to his “work spouse” Ted, also a young, Filipino-American nurse. Ted was skinny and energetic, his hair shaved on the sides and tied up in a bun on top. The pair were a comic duo; Ted the spunky and wild one and Eddy the straight man.

As the night progressed, I found Alice, Lucia, and Rita (a nurse attendant) quickly eating from the potluck before preparing to rest during their break. Alice and Rita were going to take naps and Lucia insisted I also take a moment to rest. She guided me to the adolescent room which was empty. Uncertain about sleeping alone in the patient room, I resisted. Lucia then guided me to another empty patient room where Rita and Alice would be napping. I found a spot on a patient bed between Rita and Alice. Lucia offered to grab me a blanket but I insisted she had done enough. Soon, both Rita and Alice were fast asleep, snoring softly. Meanwhile, I tried to get comfortable on the hard, rubber bed. The thin bed was just wide enough for me to roll over from my stomach to my back and placed very closely between both Rita and Alice’s beds. They both felt very close. On my back, I counted the ceiling tiles and listened to the muffled noises of activity elsewhere. The walls seemed very thin. I could hear a janitors’ cart rolling down the hallway outside. I tried to imagine what it might be like to find myself in such a bed as a patient. How the noises might bother me, or not. How the proximity of others might register. Eventually, another nurse attendant entered, in search of a bed for rest. I hopped up and offered her mine and soon Rita was awake, too. I went to the bathroom, ran my hands under cold water and tried to reorient myself.

I walked over to the nurses’ station, where I found Eddy and Rita chatting. Eddy had been filling in for Rita on her break, observing the video monitors from cameras placed throughout the ER. We chatted a bit about how I was making due during my first full night shift.

I was feeling a bit off, I admitted. Eddy and Rita were sympathetic. Between work tasks, the pair chatted about strategies for making it through the night shift. Eventually the conversation turned to the hospital itself. It was haunted, they told me, excitedly at first. Elevator 4 was especially haunted, they laughed; joking about the way the lights never seemed to work, how often it broke down. The inpatient unit was especially haunted, though. Nurses had reported a cold wind on the unit and the feeling late at night that they were being poked by something or someone. Alice soon returned from her break, switching places with Lucia. She chided Eddy and Rita. She didn't believe in "that crap," and people see what they believe. Though, she knew of a town in Nigeria where the dead rise unprompted and walk into their graves.

Just then, Miranda, began banging on the window in her quiet room. Miranda was a teenager, her circumstances and her interactions with clinical staff were beyond the scope of my ethical review board permissions. Though I cannot speak to her personal or diagnostic history, I can speak to the way staff reacted to her presence on the unit. Teenagers and children who arrived on the unit, in general, were considered "sad cases." The unit itself was designed for adults and so, most often, teenagers and children were kept in a sperate, smaller room with only three beds. To facilitate better patient supervision, Lucia moved Miranda to a quiet room where she could keep an eye on her and the other patients she was supervising. Because of her age, as was often the case with older adolescents, nursing staff wondered about the possibility of a "first-break." There was also talk of potential drug use. Responding to the noise, Alice and Rita went to check on Miranda. They returned further spooked. This was not like a normal psychosis, Alice commented. There was a thin line, she continued, between psychosis and demonic possession.

Miranda continued banging on the window. After several interventions, Alice determined Miranda would be safest if she were restrained (though Lucia would later reverse this decision).

Restraint complete, Alice returned further unsettled. No longer considering demonic possession, she wondered about possible trauma and the distinctions between drug-induced psychosis and organic psychosis; the possibility all three could be factors. This was a difficult case. It was so hard to care for people with mental disorders, Alice and Rita agreed. In some cases, Rita continued, it's almost like they are dead, but how do you grieve?

CHAPTER TWO

The “Methy Feel”: Moral Mood and Diagnostic Ambiguity in a Methamphetamine Epidemic

It was approaching 8:00pm in the Psychiatric Emergency Room, late in the summer of 2016. A busy day shift had turned into a busy night shift and the doctors who were working through the evening had not yet seen a break in the rush of incoming patients. The nursing staff, meanwhile, were focused on completing patient transfers to other hospitals. The hospital unit was humming with the busy-ness of the evening; new patients arriving in crisis, stabilized patients leaving. I walked with Dr. Zoe Banks, an intern only a few months into her residency, from the patient intake room to the doctors’ office. Along the way, she processed what had felt disturbing about an interaction with a new patient, Hector. His eyes, his gaze, she explained, pausing. They were intense, she concluded. Hector who was brought to LAPH by police, had a history of schizophrenia and had only just received a shot of Invega, a once-monthly anti-psychotic medication, the week before. The police suspected he had been using methamphetamine though it was not clear that they had communicated this fact to Dr. Banks yet.

Meanwhile, in the doctors’ office, Dr. Isaac Barrow, a fourth-year resident, was preparing a medical student, Molly, for her first intake interview. Together they reviewed the categories of a mental status exam. Down the hall, meanwhile, a new patient, Brittany, was singing “I will always love you,” Whitney Houston style. Her voice was beautiful. Glancing toward the hall as the patient’s singing grew louder, Dr. Barrow commented that it was a very manic thing to do. He tried to return his attention to the mental status exam, but—as Brittany’s singing reached its crescendo—changed his mind. They had better hurry up, he told Molly. This, he explained, was possibly a methamphetamine case. Meth cases were “bizarre,” he continued, not like schizophrenia or other illness-induced psychoses. There was a “flavor,” a bizarre one, to meth cases. He rubbed his fingers together like he was feeling the weave of a fine fabric. Then, he stood up and walked quickly down the hall. Molly, in her white coat, followed a few steps behind, pen poised above notebook for writing.

I attempted to turn my focus back to Dr. Banks and her case, but Dr. Barrow’s sense that there was a “flavor” to methamphetamine cases pulled at my attention. All summer long, I had watched as doctors negotiated cases where methamphetamine was involved. In the quickly moving ER, psychiatrists must discern whether a given patient was experiencing a primary psychiatric illness (which would involve a longer observation period and specific follow-up care), if the patient’s psychosis was methamphetamine-induced (and would therefore likely resolve itself quickly) or if there was some combination of both at work in a patient’s psychiatric crisis. This kind of discernment was not only relevant for determining the course of a given treatment plan, but also for managing the flow and pace of the hospital unit.

While the psychiatrists at work in LAPH could never close the emergency room—it must always be open—they had some control over determining how and when a patient was ready to transfer to another unit. Doctors were concerned not only with making sure there were empty beds to receive new emergent cases, though. Keeping the patient count low in the unit was also critical for maintaining a calm therapeutic environment for stabilization and recovery. Cases where methamphetamine-induced psychosis (MAP) was involved could be transferred to a new, nearby mental health urgent care center (UCC) where they could undergo a supervised detoxification and be linked to rehabilitation and follow-up care. For the busy ER, the UCC had become a critical pressure release valve and also seemed to incentivize doctors to attend more quickly to the discernment of MAP in a patient crisis.

The managed care model and the biomedical distinctions between substance-abuse disorder and other forms of psychiatric illness also inform the decision-making process for doctors on the unit (See for instance: Hansen 2019). Both DSM-IV and DSM-5 (which was a very new document at the time of research) list and elaborate substance-abuse disorder and substance-induced disorders, including psychosis, as diagnoses. Yet, managed care models that often dictate where and how public health care is practiced, have drawn critical infrastructural lines between emergency and acute psychiatric services and addiction recovery and treatment. This infrastructure also reflects a lag between medical and political ideologies about substance-abuse. While the potential for substance-abuse disorder to be considered a “chronic relapsing brain disorder” (CRBD) has been a part of medical discourse since the 1990s, general access to and funding for public assistance and care for such disorders has remained far behind such a medical model in Los Angeles.

Even while CRBD models of addiction may function rhetorically to decriminalize addiction by medicalizing it instead, treatment models still rely heavily on ideologies of individual willpower for recovery (Garcia 2010; Zigon 2010). While doctors and nurses on the unit recognize substance abuse disorder as, perhaps, a mental health concern, they also recognized it was not within the Psychiatric Department’s purview. In the midst of all of these institutional and medical distinctions of care, the presence of stimulant-induced, particularly methamphetamine-induced psychosis and disorders on the unit became the subject of much frustration and concern as clinicians navigated not only the needs of the patient before them, but also the role of the Psych ER amidst what some have identified as a growing “methamphetamine epidemic” in Los Angeles (Discussed below. See also: Lopez 2019).

Most cases involving methamphetamine are quickly recognized after clinicians confirm initial suspicions with urine toxicology reports, the patient's medical history, and collateral information from family and friends; all a matter of standard and best practices. What interested and concerned me about Dr. Isaac Barrow's "flavor," however was the notion that there were observable differences between MAP and other kinds of psychosis. Clinical research has found few if any consistent diagnostic phenomenological differences between these different kinds of psychosis (as will be discussed below). Yet, Dr. Barrow claimed a distinct even tangible difference (i.e. something that can be tasted or felt with the fingers) between MAP and other psychosis. Such a claim seemed to reflect other habits that I had observed among doctors and nurses during their initial intake assessments of new patients. Further, the sense that methamphetamine may be a factor in a patient's clinical presentation seemed to permeate not only individual treatment plans but an overall sense in the ER about methamphetamine use (See Fieldnotes One and Three). A "flavor" seemed to indicate to me that there was more to the lived experience of clinical diagnoses in these cases that warranted exploration.

When Dr. Barrow and Molly returned from their interview with Brittany, they reviewed the case. Together, they observed that Brittany was unkempt and disheveled. She had poor dentition. All were signs of potential methamphetamine use, but also potential signs of the poverty and illness not related to drug-use that characterized many of the patient cases in LAPH's Psych ER. A call from a friend not long after suggested, perhaps, Brittany was experiencing a thyroid condition that had caused psychosis. Without a blood test or a urine sample—both of which Brittany refused—Isaac could not be certain. In the meantime, the diagnostic ambiguity posed by Brittany's case (and Hector's before hers) were cast within a general awareness amongst staff in the Psych ER of pervasive methamphetamine use across LA

County. Such a mooded awareness or sensibility often came to the fore in resentful, exhausted, intrigued and anxious commentary by clinical staff about methamphetamine use, its symptoms and its consequences. It also seemed to influence over time how clinical staff related to and offered care for many of their patients. In the hours to come, both Hector and Brittany would be secluded from other patients and sedated. In Hector's case this came in tandem with physical restraint under the watchful eyes of the Los Angeles Sheriff's Department hospital patrol unit.

Though Dr. Barrow had been more direct and starker in his claims about methamphetamine-induced psychosis (again, "MAP") and it's phenomenological presence, other clinicians elaborated different forms of distinction. What Isaac called a "flavor," other clinicians identified as a sensibility or feeling. A "methy feel," Dr. Henry Torres, chair of the psychiatric department, put it pithily after one of our interviews. In this chapter, as I touch upon the state of the methamphetamine epidemic in Los Angeles, the clinical observations that have been made about MAP and the managed care models that inform how, where and when patients of public institutions receive treatment for substance-related disorders, I attend also to the affective excess—the moodedness—that informs clinical orientations toward care for patients who may use methamphetamine (i.e. "the methy feel").

Looking beyond the clinical procedures for enacting such care and even the clinical relevance of the "methy feel," I attend to the socio-cultural and individual histories and practices that elaborate this "methy feel." To do so, I rely on linguistic anthropological techniques to identify affective registers and repertoires in discussion about the "methy feel" and to elaborate the lived experience of such a diagnostic sensibility within the specific historical context of the methamphetamine epidemic in Los Angeles. In the process, I seek to articulate a kind of "methy mood" that permeated much of psychiatric emergency care during my time in LAPH. Such a mood operates not only in specific doctor-patient or nurse-patient interactions but also endures in the interim between interactions. No longer oriented toward a specific object or subject (i.e. the patient or an aspect of their behavior), this mood serves to mediate orientations to and reflections on the social context of clinical practice in the Psych ER, anticipatory observations about the future of such practice and also the moral consequences of such practice for both doctor and patient (Throop 2014, 2017, 2018).

To track the clinical relation between methamphetamine and the clinical, cultural and moral ambiguity it poses for medical practitioners, I began asking about the history of methamphetamine in the ER during interviews. When possible, I tried to elicit any specific distinctions doctors recognized between MAP and other forms of psychosis. Over time, it became apparent that a "methy feel" and eventually a "methy mood" emerged in several manners that could be delineated linguistically. First, through the experience of language practices themselves (Ochs 2012, Ochs and Schiefflin 1989), a methy mood emerged as doctors narrated the history of methamphetamine use in Los Angeles. The doctors establish a deictic field of time and sentiment to calibrate the scale of change in the patient population overtime and their positionality as clinical observers of this change (Gal 2016). The comparative work here establishes hierarchies of knowledge, which are inflected by the psychiatrists own clinical reliance on feelings interactionally established between doctor and patient.

In addition, a "methy mood" emerged through the doctors' depictions of methamphetamine symptomology, which encode elaborated clinical-language ideologies about differences in psychotic presentations. As will be discussed, such ideologies may rationalize the methodologies currently used in clinical studies of MAP and their cultural and clinical limitations. Once diagnosed, mooded attunement to methamphetamine use and its symptoms informs how doctors negotiate treatment. The immanence of a “methy mood” transcends interviews with doctors to infuse everyday clinical practice, as medical professionals reflect on treatment decisions, chat about their work and navigate the flow of the patient population in and out of the hospital.

A clinician’s diagnostic sensibilities operate alongside other tools for medical discernment (e.g. a toxicology screen or documentation of medical history) and inform a mooded sensibility about methamphetamine that emerges in the course of work in the ER. In LAPH, attending psychiatrists teach new doctors to value and honor their “gut” in the course of making medical decisions. The attunement to one’s intuition is a critical aspect of diagnostic care and treatment moving forward, even while it may be variously subordinated to the more “definitive” tools of discernment like a drug test. Psychiatric intuition is honed as a kind of *hexis*, a relatively fixed disposition formed in relation to the world and others, that is established in the course of clinical practice as doctors habitually work toward prognosis (Bourdieu 1977, 1985). Here, psychiatrists attune not only to the physical symptomology of an illness or the propositional content of a patient’s utterances but also the affect conveyed in the course of an interaction.

In “Fieldnote One,” for instance, while I found myself attuned to Roger’s (the patient’s) denial of a mental health issue, Dr. Walsh attended to Roger’s “energy” as it elevated (Fieldnote One, 8). This “energy” is not just “out there” or in the patient but also registered by clinicians in their own bodies. As Dr. Walsh told me in an interview: “Part of the training in psychiatry is to make people aware of themselves. They’re their only instruments to help someone. We don’t have stethoscopes and hammers, stuff like that. We just have ourselves.” Dr. Barrow’s choice of words (“flavor”) and the way he gestured toward this “flavor” by rubbing his fingers together both speak to how doctors refine their attention to patient care by orienting it beyond the patient toward themselves in the doctor-patient interaction, as a mechanism for medical analysis. While an “energy,” “flavor,” or “feel” may emerge across doctor and patient over the course of a single interaction, it also resonates at various levels of amplification and awareness over the course of a day, week, or years of clinical practice; becoming something less precisely about an individual patient than about the experience of practicing emergency psychiatric care amidst a methamphetamine epidemic (Lepselter 2016, Throop 2014, Wikan 2012). This resonance is assisted by repeated interactions with the same or different patients in states of similar crisis (in this case methamphetamine-induced) over time.

I have begun to understand such diagnostic resonance in relation to mood. Elaborating the sensibility or awareness that emerges within this resonance in mooded terms opens up a space for considering the varieties of emotions and feelings that often present themselves in a particularly mooded atmosphere and their moral consequences. Importantly, I take a distinctly phenomenological approach to mood as opposed to or alongside the more pathologized, diagnostic and treatment approaches to mood used by psychiatrists themselves. Psychiatry has long made an effort to make discrete, diagnose and intervene in the moods or mooded experiences of others (we need only look so far as the various iterations of the Diagnostic Statistic Manual, for instance). While acknowledging the influential role of this historical and clinical relationship with moods, I engage a more expansive phenomenological perspective that positions mood as disclosive of experience as it is it is variously oriented toward a “world-horizon” (Throop Forthcoming), that is the limited yet changeable expanse of meaning and understanding in a given context (See: Introduction). In this case, mood discloses the limits of possibility for care, treatment and moral being in the hospital as it relates to methamphetamine use.

This sense of mood is decidedly atmospheric (See: Throop Forthcoming) so that I may notice a swirl of emotions, sentiments, cultural, political and moral sensibilities that emerge in a given mooded situation. While a happy mood may provide the context for reflecting upon the interaction at, say, a birthday party, other emotions—nostalgia, excitement, even, perhaps sadness—may inform the way such a mood takes shape and is diffused over the course of the event and after. Within the various resonances that shape a mooded relation to the methamphetamine epidemic, ambiguity, anxiety, resentment and exhaustion inform how an awareness of methamphetamine is amplified and attuned to in the ER. I simplify this experience as a "methy mood." The goal in such simplification is to capture an ambiguous but nevertheless thematized set of experiences around the occurrence of MAP and other methamphetamine related encounters in the ER. While a "methy feel" may be directed at or emerge from a particular patient encounter, a "methy mood" names the more diffuse and often ambiguous awareness or orientation to such encounters over time.

The temporal and moral operation of moods are particularly important to this analysis. Moods not only draw on and are articulated through past experience in concrete and residual forms, but also operate in anticipatory ways (Throop 2014). In the case of a "methy mood" temporality comes into play at historic, interactional and future-oriented ways. Clinicians reckon with ongoing individual, cultural and institutional histories that have shaped the emergence of the "methamphetamine epidemic" in Los Angeles and its consequences for the operation of care in the Psych ER. As a "moral mood" (Throop 2014), the ambiguous but nevertheless felt presence of a methamphetamine epidemic serves as the means through which ongoing negotiation occurs about the correct and ethical treatment for a patient and—at a more existential level—a clinician's own moral being-in-the-world in relation to such treatment as enacted between people and via institutional mandates. In this way, the "methy mood" as "moral mood" notes a relation to care that is in flux and open for negotiation. These aspects of mooded reflection can be traced in the ways doctors talk about the history of methamphetamine on the unit, the identification of methamphetamine use in individual cases, and their own moral reckoning with treatment options. In the section which follows, I mobilize a linguistic anthropological analysis to reveal the operation of mood in the speech of clinical staff, particularly attending psychiatrists. Through this approach I seek to elaborate mood and affective experience by taking language as experience itself. As I hope to show, Anthropologists and scholars who seek to elaborate mood and affect have much to gain in taking language seriously.

"It Just Seems:"
Charting the Ambiguous Yet Definitive Feeling of Change in the Psych ER

By late winter in 2017 I began to hone on a series of questions related to methamphetamine use in the ER and its treatment after observing countless conversations about the drug in triage and treatment contexts. During an interview Dr. Walsh outlined the kind of cases that are eligible for transfer to the Urgent Care Center. His assessment was ratified in two additional interviews with attending psychiatrists and in informal post-intake interviews with clinicians as they worked. These cases were generally grouped into two to three categories. The first category listed by all three attending psychiatrists were those cases of methamphetamine-induced crisis, because such cases could be resolved so quickly. The next categories were situationally restricted instances of suicidal ideation, where patients were responding to either a specific stressor that could resolve itself with the follow up care available at UCC or did not have a direct or clear plan and a generalized “other” category that involved patients who had been stabilized and were calm and cooperative. In the course of outlining each category, I asked doctors to explain their clinical process for identifying such cases. With regard to methamphetamine-induced cases particularly I also asked about the history of methamphetamine on the unit and the process for diagnosing such cases.

Dr. Henry Torres was the first person with whom I explicitly posed this set of questions, after my interview with Dr. Walsh. In the excerpt below, transcription conventions track the pace and intonation of speakers, as we work through the history of methamphetamine on the unit. Arrows mark discourse relevant to the analysis that follows.[32]

Abby: In the past you’ve mentioned that that[33] seems to be **uh-**[34]one of the causal
factors of the increase in the census?[35]

Dr. Torres: mm-hmm

→ **Abby:** **Um.** So. **Uh.** I was wondering about when you: noticed that kind of
<uptick in methamphetamine use.>

Dr. Torres: ((clicks tongue)) I don’t know if I could re-like, point to it. **Um.** But I-I do
→ that when I first-uh started here-**uh** in the Psych ER. It wasn’t as
prevalent.

Abby: mm-hmm

Dr. Torres: **Um:: (.) Eh-**I mean **eh:::** you saw more – all—**eh::** - It seems like it’s-it’s
→ taken: the number one spot in terms of substances. >That’s how it feels<
like- It used to be more like maybe I would give – I mean marijuana is
pretty ubiquitous. **Uh.** Alcohol maybe-**uh-**related issues were more
→ prevalent than-than that when I first started here. But, it just seems like
meth has been really-**um (.)** on the rise.

Abby: mmm
[

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[32] See appendix for transcription devices used. “→” Represents a line in the conversation relevant to analysis.

[33] Methamphetamine use

[34] Filled and unfilled pauses are placed in bold lettering to ease in reading the transcript.

[35] The number of patients present in the ER on a given day.

Dr. Torres: I don't know. If I'm gonna put a time period to it. I would say probably-**um** in the last six years? Seven years?
[

Abby: mm
[

→ **Dr. Torres:** That it ::started?
[Alternate Transcription: That it's started]

Abby: I see

As Dr. Torres attempts to "point to it"—that moment of first noticing a rise of methamphetamine cases—linguistic markers of both uncertainty and certainty emphasize an ambiguous yet definitive turn in his clinical experience. Throughout the interaction, verbalized or filled pauses—"um," "uh" and "eh"—index the uncertainty and ambiguity that operates as a core aspect of how a "methy mood" is felt and mobilized in relation to the rise of methamphetamine use. More than "filler words" these markers allow speakers to tread slowly as they broach sensitive topics (Saks 1992). Hesitancy emerges first as I work through how to ask the question and approach a topic that was, from my understanding so far, fairly ambiguous and unmeasured in the ER: "Um. So. Uh. I was wondering…" Filled pauses are coupled by a slowed pace, as I draw out "you:" and stretch out the phrase "<uptick in methamphetamine use.>"

Dr. Torres, meanwhile, meets this uncertainty with his own uncertainty while moving toward a kind of definitive moment at which he could, perhaps, point to a change. "When I first-uh started here-uh," is followed by emphatic stress on the adverb "as" in "wasn't as prevalent." Still not a definitive statement, the comparative between then and now in this sentence indicates an imprecise yet tangible change. The comparison casts the existence of methamphetamine into a set of relations across time and between patient cases and the symptomology of these cases.

Dr. Torres emphasizes the “felt” aspects of this change in his next turn, when he qualifies his sense that things used to be different with a quick but firm: “>That’s how it feels<.” As he directs me toward feeling, he makes several moves. First, he iconically indicates that there is a definite feeling of change, as emphasized by how quickly he makes this statement after a fairly drawn out and hesitant opening (“Um:: (.) Eh-I mean eh:::”). Next, Dr. Torres mobilizes and emphasizes the deictic “that,” indexing” his relatively conclusive sense -- compared to the more momentary “that’s how it feels”—that methamphetamine use has “taken the number one spot.” Importantly, Dr. Torres’s “That’s**”** also gestures back to his earlier comparative “wasn’t as prevalent,” limiting the scope of what is knowable to the course of his career. Finally, in uttering “>That’s how it feels<” Dr. Torres indexes a moral hierarchy of kinds of knowledge, pitting his feelings against a more definitive form of knowing.

This deictic field is elaborated later when he explains: “But, it just seems like meth has been really-um(.) on the rise.” Here, “it just seems” tacitly refers to a felt situation, a condition of being, that operates in tandem with “that’s” to maintain a phenomenological field of relations between Dr. Torres and the rise of methamphetamine use in the ER, and between Dr. Torres and me over the course of the conversation. When Dr. Torres says, “it just seems,” the adverb “just” and the verb of perception “seems’ mitigate the otherwise emphatic statement, “ meth has been really-um(.) on the rise” and articulates Dr. Torres’s relation to what he can and does *know* about methamphetamine use in the ER. The utterance : “But, it just seems like meth has been really-um(.) on the rise.” aligns with his practice as a psychiatrist, where feelings and explicit forms of attunement are ratified but nevertheless placed in tension against more statistical or definitive forms of knowing.

Though Dr. Torres appears to further mitigate his own sensibilities by couching his estimations about the rise in methamphetamine use with rising intonation (“six years?,” “seven years?” and “that it ::started?”), his assessment aligns fairly well with statistics available about the methamphetamine rate in Los Angeles. The Substance Abuse Prevention and Control program (SAPC) in LA’s Department of Public Health presented a few recent statistics that indicate a sharp increase in methamphetamine use throughout LA county. SAPC sites a report from the US Drug Enforcement Agency that documented a 1,706% increase in methamphetamine seizures by law enforcement from 1986 to 2017 (SAPC 2019). The cost of the drug has declined as supply has increased throughout the county. SAPC also calls upon statistics from the Department of Health Services and other hospital research to document a 604% increase in emergency hospitalizations related to methamphetamine use from 2008 to 2017 (ibid). Finally, the SAPC documents that lifetime use rates of methamphetamine are at their highest in Los Angeles in populations aged 26-35, which is also a key population treated in LA’s public emergency psychiatry departments (SAPC Data Brief 2019; Ochoa et al 2015). All of these statistics appear to support Dr. Torres’s sense about the rise in methamphetamine use, though none of them precisely indicate the impact of methamphetamine distribution and use on patients and clinics so clearly, from my perspective, as Dr. Torres’s ambiguous but nevertheless definitive sensibilities as they manifest affectively in his speech and practice.

Both Dr. Torres’s estimates and the statistics listed above provide a sense of scale. As Susan Gal (2016) has elaborated, the discursive and semiotic work that underlies efforts at scaling is ideological. Undergirding the work of scaling a problem or a phenomena is a great deal of effort to differentiate and compare problems. The SAPC statistics do not look, for instance, at how methamphetamine rates and hospitalizations may be compared to instances of heart attack.

Instead, hospitalization rates are cast alongside drug enforcement statistics, drawing a sense of scale in relation to disciplinary efforts of the state. While SAPC statistics attempt to address this scale from an institutional "view from nowhere" or the "state's eye view," Dr. Torres's measurement of the problem is decidedly, explicitly subjective. As previously mentioned, the tension in Dr. Torres's articulation between a specific set form of knowing about methamphetamine rates in the hospital and his own feelings about it is a critical aspect of the way psychiatrists in LAPH balance their own cultivated sensibilities and expertise with the medical diagnostic tools that reveal "hard" facts for clinical prognosis and treatment. The habit of balancing professional feeling against these harder forms of knowing and its accompanying tension was exemplified by Dr. Bill Walsh as he discussed his changing responses to methamphetamine-related cases:

Abby: In terms of-um- your history as a clinician, has-has methamphetamine and drug-use been more of a causal factor in the increase?
[
Dr. Walsh: Yeah.
[
Abby: ((quietly)) in patients?

Dr. Walsh: Yeah. I would say. I did-uh-couple of years ago I took two months-three months and went through all::: the urines.

Abby: mm-hmm

→ **Dr. Walsh:** And found about <u>what</u> percentage are drug induced and I would say I got ten to fifteen percent. It's probably twenty to twenty-five percent now.

Abby: Okay.

→ **Dr. Walsh:** I ha-I haven't done it but it's just- I don't go down there[36] on a shift without having some drug-induced-meth-induced psychosis.

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[36] To the Psych ER. Bill worked primarily as a consulting psychiatrist to the rest of the hospital, but also worked at least one shift in the ER at the time of research.

Abby: mm. mm-hmm

Dr. Walsh: Or altered behavior. Running in the street naked. Stuff like that.

In an earlier interview (June 2016), Dr. Walsh reflected on a steady increase in patients, wondering if the summer weather had some influence on the rise in patients before noting, “I’ve been str::uck by the amount of meth psychosis we’re getting in.” Dr. Walsh drew out “str::uck” to iconically emphasize the experience of observing such a change across the patient population. By February 2017, when the interview above took place, Dr. Walsh felt certain that methamphetamine-use had been on the rise and become exhausted by this felt rise as it impacted his work in the emergency room. He interrupted my question about his historical experience with drug-induced symptoms with a quick, firm “yeah.”

Dr. Walsh, like Dr. Torres, first framed his experience with an attempt to quantify the scale of his encounters with methamphetamine and drug-related cases. He had done a quantifiable study of drug-related cases a few years earlier after reviewing “all:::” the urine toxicology screens (where the long drawn out “all:::” indicates thorough review). He did not have those same quantifiable data to rely on now, though he estimated the percentage had doubled in the years since his last investigation. Like Dr. Torres, Dr. Walsh mitigates this estimation through the modifier “just” and by haltingly expressing the justification for his estimate of the rising percentage of cases: “I ha-I haven’t done it but it’s just. I don’t go down there… .” Here, “it” again references a situation, a present condition in the ER that *is* “just,” Against any “certain form of knowing” (i.e. statistics), the sense, awareness, feeling—the mood—about methamphetamine related symptoms and their presence in the ER “just” exists.

What I have called the “methy mood” is present for the clinicians (according to their self-reports) both as they carry out their work in Psych ER and as they reflect on drug-induced psychosis during interviews. Dialogically constructed over the course of conversations with Dr. Torres and Dr. Walsh, the methy mood emerges through their accounts of symptomology and, especially on Dr. Walsh's part, emotional responses to treating people experiencing such symptoms. Part of the methy mood as it is felt and negotiated at least by Dr. Walsh and Dr. Torres involves mitigating these feelings, hedging them against other more seemingly certain ways of knowing about methamphetamine-related cases. In the process, relations are drawn between what is and can be known about such cases and their presence on the unit. In being notable, instances of MAP stand in distinction from other cases and speak to the way clinicians give diagnoses and how they understand and articulate the scope of their clinical knowledge.

While particularly mooded ways of being may inform how a person experiences methamphetamine-induced psychosis (see below), the methy mood that emerges in the excerpts above is one which is uniquely experienced by clinicians who have perspectives on the situation (i.e. the methamphetamine epidemic) that is shaped by returning patients, repetitions of experience with these patients, and clinical habits of embodied discernment within the hospital. Such a mood is formed more directly as various doctors get the "methy feel" in clinical interaction and respond to the moods of patients experiencing MAP.

Hopped Up, Ramped Up, Amped Up: Clinical-Linguistic Ideologies of Methamphetamine-Induced Psychosis

Both Dr. Torres and Dr. Walsh reported that their primary means for identifying someone who is experiencing a methamphetamine-related crisis were urine toxicology screens, the patient's medical history, or collateral reports from friends and family of the patient about substance use. Still, by the time of my interviews with Dr. Torres and Dr. Walsh, I had collected a trove of field observations after intake interviews during which doctors and nurses reported their sense that the patient was using methamphetamine before any such definitive information (screens or reports) was readily available. I pushed Dr. Torres and Dr. Walsh to describe further their clinical observations of methamphetamine-related cases. In response, Dr. Torres detailed the physical symptomology common in long-term methamphetamine use after reflecting on the potency of the drug and the way it impacted patient behavior:

Dr. Torres: And, and you tend to see-I mean folks can look very, very aggressive on meth.

Abby: So, can you gen-generally tell if a person is on methamphetamine when you encounter them at this point?

Dr. Torres: S-you know-sometimes you can. Um. But you can't-I mean. Like you can still be::co-Sometimes it's difficult to tease out whether it's a primary psychotic illness or not. Uh. (.). You know, like there's been cases - O - Obviously, if you get a patient who has a history of meth (.) chart and then you go see them – the eyes are injected. They look restless. They have bruxism where they're like kinda doin' this ((demonstratively grinds teeth from side to side)) with their teeth. Um. Sometimes I've even seen folks that have the odor – this chemical odor.
[
Abby: hmm
[
Dr. Torres: About them. Um ((clicks tongue)) so, those are some of the – the signs. Uh. Somebody who has muscle wasting. Um-uh poor dentitio::n. Um skin kind of lesions on their face. Uh. Maybe on their lips too from burns from pipes.

Abby: mm.

Dr. Torres: Those things kinda will push you towards like, "This person looks like they're probably using meth."

Dr. Torres then compared the symptoms of chronic methamphetamine use with those in a patient with a known history of schizophrenia. A patient with schizophrenia and no history of drug use will present with more "negative symptoms –a flat affect. Um. Impoverished speech. Um. And thought disorganization as their prominent kind of presentation." Dr. Torres continued to elaborate the complications that ensue when a patient is experiencing both a psychiatric illness and methamphetamine-induced psychosis and the tricky similarities between the two illnesses for clinical treatment. This problematic will be discussed further later in the chapter. Meanwhile, Dr. Walsh described a more elaborated but similar assessment of methamphetamine-induced psychosis, turning to the affective changes which may “key” him into the diagnosis.

Abby: So, what are some of the things you look for clinically-um-when you’re trying to decide if a person is experiencing a drug-induced psychosis versus-uh-

Dr. Walsh: ((clicks tongue, inhales)) History

Abby: ‘kay.

Dr. Walsh: U:::m the amount of agitation and the amount of aggression (.) is not as typical with your primary psychosis.

Abby: Okay.

Dr. Walsh: Um. The degree of confusion versus disorganization. They’re high and so they are more confused than they are disorganized. (4 seconds).

Abby: I see. Could you explain that a little bit?

Dr. Walsh: Um. Confused is more of a state of consciousness and attention. (.) Disorganization is in a normal consciousness and normal attention (.) the content doesn’t make a whole lot of sense.

Abby: mm.

→ **Dr. Walsh:** So. The drug induced are drug-craze type. So, they can be more (.) I mean they know the date and stuff. If they don’t know the date and stuff like that then that’s-that’s real confusion and they go over to the medical.

Abby: hmm.

→ **Dr. Walsh:** (.) ER. But if they’re more just hopped up (.) That’s not a very clinical term, but ramped up.

Abby: mm.

Dr. Walsh: Taking five and six police officers. Stuff like that. Often times that’s drugs or drugs plus primary psych.

Abby: Okay.

→ **Dr. Walsh:** The dramatic-ness of the presentation keys me into it. The other thing that keys me into it is that they're twitching. They're moving around a lot. Their mouth is in unusually varied disarray. Um (.) they're not taking care of themselves. ((Inhales)) You see that with primary psychosis but it's usually mu::ch—not as amplified.

Abby: Okay.

→ **Dr. Walsh:** It's more of a negative state of not taking care of yourself rather than this amped up state where you—torn clothes and dirty and stuff like that.

In the excerpt above, Dr. Walsh, like Dr. Torres, distinguishes MAP from other forms of psychosis first in terms of aggression. He then outlines several more spectra across which MAP may be located and identifies that these include spectra of amplification or energy, thought content (disorganization) and orientation to the world (confusion). While he uses clinical terminology to outline the symptoms at either end of the various spectra, the points along these spectra are "not very clinical." Instead, Dr. Walsh outlines forms of energy that describe a "drug-craze type." This energy is "hopped up," "ramped up," and "amped up." As he seeks to differentiate this behavior from primary psychosis, he indexes various ideologies about psychosis that have informed studies of MAP for nearly a century.

Since at least the 1930s, amphetamine and stimulant-induced psychoses and their distinctions from and similarities with forms of primary psychoses have intrigued and troubled medical researchers who have worked to identify key diagnostic distinctions in mood and other symptoms of psychosis and MAP(See for instance: Young and Scoville 1938; Connell 1958; Jönsson and Sjöström 1970; Tomiyama 1990; McKetin et al 2006; Ujike and Sato 2004; McKetin 2018; McKetin et al 2017). In 1990, Tomiyama outlined a series of distinctions between MAP and psychosis resulting from chronic schizophrenia. There, Tomiyama observed that while anhedonia, apathy, or blunted affect was present in both forms of psychosis, it was less common in MAP. This study gained a great deal of attention (See for instance: McKetin et al 2017), and may be—at least in part—what underlies both Dr. Torres and Dr. Walsh's orientation toward MAP as an active state of psychosis when compared to schizophrenia.

In the decades since Tomiyama's article, however, researchers testing these observations and seeking further distinctions between MAP and primary psychosis found few consistent differences. The complications in making these distinctions was further complicated when researchers considered the co-presence of both MAP and psychiatric illnesses, the relation between heightened energy that comes with methamphetamine use and mania that might present in cases of bipolar or schizoaffective disorders, and the long-term effects of methamphetamine use for the presentation of MAP over time. In a recent study attempting to control for some of these concerns, McKetin et al (2017) noted a new distinction between the various contents of delusions that emerged between people experiencing MAP and those experiencing psychosis from a psychiatric illness in a study conducted in Australia. Further research in cohorts across the world would be needed to affirm this study; however, it points to the ways that embodied communicative ideologies about psychosis and its presentation operate in diagnosis. It also offers some grounds for understanding the effort to differentiate that manifests in Dr. Walsh's articulation of MAP as "hopped up," "ramped up."

Underlying the distinctions between MAP and primary psychosis are enduring diagnostic ideologies about psychosis in psychiatric practice. Here, psychosis can be delineated into discreate symptoms (e.g. delusion or hallucinations) and within those categories even more discrete categories related to content (e.g. delusions of grandeur or persecutory delusions, for instance). Such delineations are outlined in literature like the DSM-5 which, in turn, informs how a doctor codes a given patient note for insurance companies. Though MAP and primary psychosis are understood as distinct, the categories and differentiations that were defined in relation to primary psychosis are used to understand and articulate MAP in practice and in clinical literature. In turn, researchers have used MAP as a mechanism for understanding the neurobiology and symptomology of primary psychosis (Murray et al 2013). As such, fractal recursivity (Irvine and Gal 2000; Gal 2016) takes place over time, across scholarship, and in clinical practice—as comparative language steadily builds, referring back to and across various states of psychosis. Contrastive idiosyncrasies emerge to bolster diagnostic sensibilities (e.g. “feel” vs “flavor”) that are upheld by clinical ideologies. This process of diagnostic differentiation embraces both a recognition that MAP and primary psychosis are similar and perhaps related and an effort – perhaps even a professional obligation - to hold these forms of psychosis as discrete and separate, even—as is the case in public health care in Los Angeles—relegating these now identifiably distinct forms of illness to different kinds of treatment and clinical settings.

The tension between holding these forms of psychosis in distinction while relating them emerges in Dr. Torres’s final reflection on the symptoms of MAP:

> **Dr. Torres**: There’s also some cases where somebody’s used meth for such a long time. And mind you-like meth is neurotoxic. Um. They’ve used meth for such a long time that now they are just indistinguishable, you know,
> → **indistinguishable** from somebody who had chronic schizophrenia. **Even have like the (.) movement disorders** you would see-um- with people that are on neuroleptics for a long time.

Dr. Torres’s comparison of long term methamphetamine use, MAP, and treated chronic schizophrenia speaks to additional studies which problematize current emergency responses to MAP. Drawing on clinical research of a cohort of strictly methamphetamine users in Japan , Ujike and Sato (2004) outline an intriguing etiology for MAP that further complicates and problematizes efforts to distinguish psychoses and the infrastructural responses that emerge in these distinctions.

In Japan, where methamphetamine has been the most popular drug for nearly 50 years, rising to epidemic levels in waves that occurred just after WWII and again in the 80’s and 90’s, these authors outline three core characteristics of the progression of MAP in instances of chronic use. First, as people who use methamphetamine become sensitized to the drug, they undergo a series of mental alterations (caused by the flood of dopamine released by the drug) that lead from nonpsychotic to pre-psychotic and eventually severely psychotic symptoms (283-284). Next, while MAP is characterized as fairly short in duration (no longer than a month, but frequently much, much shorter), chronic methamphetamine use may lead to an “enhanced vulnerability” to relapse of psychosis not only in the case of substance use but also when people who chronically use the drug experience social stressors (284-285). Finally, the vulnerability for relapse may extend for years. Even a person who has completely abstained from methamphetamine use for years may experience psychosis in their first re-use (286). Along these lines, McKetin et al (2017), found, meanwhile, that persistent MAP may “reflect the precipitation of a primary psychotic disorder” (352). While McKetin et al make a distinction between transient MAP and persistent MAP, their study was unable to track lifetime use beyond a few years or other drugs which may have been used. Ujike and Soto’s study, meanwhile, suggests that the first onset of MAP may be akin to a first break of primary psychosis, as users progress from nonpsychotic to severely psychotic behavior over the course of their use. Such a framework for MAP raises questions about the long term efficacy of distinguishing MAP from primary psychosis in emergency triage. While, on the one hand, discerning between MAP And primary psychosis is relevant to a degree for clinical response, it also makes infrastructural responses that relegate people with MAP to short-term and hard-to-access rehabilitative care and supports sometimes tacitly ongoing moral responses to MAP that criminalize addiction.

The Epidemic and the Will to Change:
Articulating a Moral Relationship to MAP and its treatment

After it has been diagnosed, another important set of comparative distinctions and relations emerges in considering the treatment course for patients experiencing MAP in LAPH. While methamphetamine is marked as distinct from other drugs in its potency, it is nevertheless compared to and measured against other forms of substance use (Recall how Dr. Torres articulated the rise of methamphetamine use in relation to marijuana and alcohol). Because MAP is the result of addictive or extended use of methamphetamine, the clinical response to this form of psychosis draws on general and generalizing models of addiction recovery where the nature of the particular substance is not as relevant as the individual will to recover. In some instances, this disposition leads to implicit and explicit articulations from clinical staff about who is worthy or otherwise deserving of care and attention in the psychiatric emergency room. Such a moral distinction was troublesome for Dr. Walsh, who stressed the value of clinical empathy and consistent care to the residents he trained. Yet, as he saw the same patients return in states of MAP, Dr. Walsh grew tired. After Dr. Walsh described the repeated exposure to methamphetamine cases that he was experiencing in the ER, I asked him about its impact on his practice as a clinician and teacher.

Abby: Has that changed the way you approach. Um:: training residents?

Dr. Walsh: Um. I thought you were gonna say has it changed your approach to them?

Abby: Has it?

Dr. Walsh: Um (3 seconds.) I have less tolerance, yes.

Abby: Why is that?

→ **Dr. Walsh:** (10 seconds.) That's a good question. It shouldn't matter (.) Cause drug
→ addiction is an illness, too. ((Heavy sigh)) (.) I think it's human nature if
someone keeps coming in over and over and doesn't want to address the
problem that your less likely to put a full court press trying to get 'em
→ resources if they're not ready. It's the nature of drug addiction. ((Inhales))
Generally if it's repeated which most of these are. You lose a certain
amount of (.) energy to get them hooked up.

Abby: mm-hmm.

Dr. Walsh: When they keep refusing to be hooked up and keep coming into the
emergency room taking up resources. It's-it's not that they can tell: that
I'm different. It's just that ((inhales)) um. I mean I still try to get rehab,
but if they say no after the fifth time, I don't keep pursuing it. If they say
→ no the first time, I'll pursue it more (.) But in fact, you can't predict when
somebody is going to be ready so you should try every single time. So. I
→ think-we talk about countertransference in psychiatry. And I think that as
attendings we also have to model good behavior, good clinical behavior.
And I think that I have to work against becoming somewhat hardened or
callous. When I was doing medicine down at [Public Hospital] for ten
years. PCP was very big in the seventies and eighties and that was – they
were so aggressive and so ungrateful that it was hard to co::nstantly keep
up a good mood with these kinds of patients and I'm finding a little bit of
that with the meth epidemic and it's clearly an epidemic.

In the excerpt above, Dr. Walsh directs the line of focus away from his role as teacher and toward his role as clinician. In the pauses, hesitations, heavy sighs and inhalations, it becomes clear that his negotiation of his role as clinician when it comes to providing care for patients experiencing MAP is both emotionally taxing and unresolved. Because drug addiction is an illness, the fact that a patient has an addiction "shouldn't matter." Yet, much to Dr. Walsh's chagrin, it *has* mattered, and in this interview it continues to matter as Dr. Walsh has become intolerant. As is his "human nature" Dr. Walsh has become attuned to the repetitions of methamphetamine related cases and the resonance between them. In the process, the "countertransference" that Dr. Walsh names and experiences works to create a "kind" of patient and his history of caring for patients who are “ungrateful” to which Dr. Walsh is responding rather than any singular patient before him. The intolerance and exhaustion that accompany this countertransference emerges in material, embodied form in Dr. Walsh’s heavy sigh. The moral ambiguity posed by such cases and the resonance between them become a critical aspect of the mooded response to this phenomenon as it emerges in the excerpt above.

The moral negotiation that takes place over the course of Dr. Walsh’s reflection on what he identifies as an “epidemic”[37] is informed by an enduring tension that exists between medicalized and criminalized articulations of drug addiction. At the heart of this tension are moral ideologies of abstinence-based recovery models and, in Dr. Walsh’s case, a doctor’s moral obligation to treat illness. Yet, this is about more than Dr. Walsh’s positionality as a doctor, it is also about his fidelity to this position, his moral sense of self, and his moral assessments of others—his patients—with whom he shares a world (Zigon 2014). This comes to a particular fore when Dr. Walsh navigates the relation between the individual, the individual will, and recovery in his clinical practice and as a teacher. In his role as a mentor to resident doctors, Dr. Walsh addressed treatment for patients with addiction by observing residents at work, holding the residents accountable for the care they provide, and also teaching residents that “this is a medical illness and that most people probably would not choose this after a certain point. They’ve lost their choice.” Dr. Walsh continued:

Dr. Walsh: Um. It’s not a matter of will power. Eh:: the – will power is a very interesting thing. You’re not responsible – this is what the AA and twelve step programs say and I <u>totally</u> buy into it. You’re not responsible for
→ having an illness, but you’re responsible for your own recovery. Which means you can do a meeting rather than use the drug. So you have to make

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[37] Though use rates have grown in Los Angeles, they remain lower than many methamphetamine use rates across the United States. What qualifies as an epidemic is of particular interest here as is the temporality of an epidemic; when it reaches a peak, when it is said to have started.

the decision on a daily basis. That's why you go to meetings daily. You can make a decision to use or be in recovery.

Abby: mm-hmm

Dr. Walsh: An::d, <u>that</u> you are responsible for. So if somebody continually rejects recovery. Then you have to in some way put the responsibility back on them. And that's where the tough love comes in. ((Inhales)) We can be confrontational and still be empathetic and I think teaching someone to know how to confront <u>that</u> and still be empathetic and the way you do that is you don't have a judgement behind it. You call it what it is without emotional judgement behind it. "You're an addict. You need recovery.
→ This is not working. You <u>don't</u> belong in the emergency room. Um. <u>No</u> I'm not going to give you Xanax and no I'm not gonna support this and <u>yes</u> you are gonna go to a shelter now that you're sober. No I'm not admitting you to the hospital <u>because</u> of your behavior and because you're not accepting responsibility." You can say that the way I just said that without much judgement but it is the facts. And that is what you tell them.

In the excerpt above, Dr. Walsh begins to articulate a particular pathology of the will (cf. Good 2010) that has been elaborated by Alcoholics Anonymous and other abstinence-based twelve step programs and Dr. Walsh's understanding of these programs (Garcia 2010; Zigon 2010, 2019). Here, "will" endures while the individual is sober but is lost once they have made the decision to use drugs or alcohol. To understand the moral repercussions of this pathology on Dr. Walsh's negotiation of teaching and treatment in response to drug addiction, it is useful to perform a cluster-agon analysis of the excerpt above. This kind of analysis, which was introduced by Kenneth Burke (1984) and developed by rhetorical scholars, looks simply at "what goes with what" and "what is opposed to what" (See, for instance: Berthold 1976). Above, Dr. Walsh uses responsibility and "will" almost interchangeably. Just as the will to choose recovery may be lost while an individual is under the influence of a particular substance, so too is responsibility for that recovery. Dr. Walsh positions this as an amoral, medical concern—one which he may be able to attend to without judgement—yet, simultaneously moralizes this lack of will by placing it in opposition to a need for medical treatment.

This moralizing becomes apparent when Dr. Walsh lists a set of non-judgmental statements—"facts”—which may be delivered to patients in order to “put the responsibility back on them.” Again, patients who use methamphetamine or other substances become typified. Such typifications are reinforced through repeated use of the impersonal second person pronoun ‘you’ (e.g. “You’re not responsible for having an illness, but you’re responsible for your own recovery.”) and the anonymizing indefinite pronoun “somebody” (“So if somebody continually rejects recovery… .” These patients who are “addicts” are patients who seek unnecessary drugs (“No I am not going to give you Xanax”), are patients who are unhoused (“yes you are going to go to a shelter”) and, most importantly are patients who do not “belong in the emergency room.” The hypothetical patient to whom Dr. Walsh is responding seems to be seeking care, and yet, Dr. Walsh makes it clear that their behavior and lack of responsibility make them ineligible for such care. It is, then, the moral, even “empathetic” thing to do as a doctor to exercise “tough love” to refuse access to care so that patients may, as Dr. Walsh detailed later, become “sick and tired” of being “in the gutter” and choose recovery. This moral protocol follows an AA logic that some people may need to hit bottom before they can choose recovery for themselves.

Dr. Walsh acknowledged earlier in the interview that public rehabilitation centers have long waitlists and problematized the way some administrators use this waitlist to weed out those people who were not ready for rehab. Dr. Walsh had also acknowledged that the desire for recovery could change at any time. Yet, he ignores the structural and institutional barriers to care in the excerpt above. While Dr. Walsh extends latitude for those patients with mental disorders who may or may not have an awareness about or ability to choose psychiatric care and treats such patients involuntarily, patients experiencing addiction are *individually* responsible for their recovery. Dr. Walsh, then, forecloses many possibilities of care and being-with patients experiencing MAP by casting the path to recovery as a singular and individual one for which there is no current, accessible venue. Rather than view this distinction as a critical oversight, I understand this contradiction as part of Dr. Walsh's ongoing negotiation of his own intolerance and its potential influence on his own moral standards of care.

Later in the interview, "will" emerged again when I pushed Dr. Walsh to elaborate for me the way that financing for rehabilitative care informs the process of treating patients with addiction.

Dr. Walsh: Well, my feeling is that if we took the money that we spent on the drug war for rehab we'd have plenty of money. Just marijuana alone. But if you add some of the others, uh:: there'd be plenty of money. It's just there – it's not our will to recover (.) people. It's our will is – to punish them for using drugs.

Abby: "Our" be::ing

Dr. Walsh: Society.

Abby: mm.

Dr. Walsh: Cause that's the way society acts.

This turn of the conversation complicates the earlier discussion. By aligning himself with society ("our," "we"), a collective with the "will . . to punish" rather than "recover" people who use drugs, Dr. Walsh seems to acknowledge his moral stance within a larger socio-political structure in which penal responses to addiction are financially prioritized. Dr. Walsh recognizes that societal priorities inform how "we" treat addiction precisely by individualizing it in punishment and criminalization. Like a patient experiencing addiction, society itself de-prioritizes the will to recover and is morally culpable for its priorities. A will that belongs to society belongs to no one in particular. In this logic, though he is a part of society, Dr. Walsh does not feel obligated to or that he can change the will of society. Over the course of the interview, as he orients toward meth use in Los Angeles as an "epidemic," as he positions himself in a "society," Dr. Walsh articulates a sense of scale and temporality in which he as individual doctor is overwhelmed and will keep being overwhelmed by both the number of patients and lack of societal support.

The Stickiness of the Methy Feel and Foreclosed Possibilities

While Dr. Banks wrote up her initial intake interview in Hector's medical file, Brian, a night-shift nurse was tasked with checking Hector into the patient room and getting his medications. Brian introduced himself to Hector and I spoke with the police who brought Hector in to LAPH. "I actually feel sorry for this guy," one of the officers told me. The officer suspected Hector had been using methamphetamine, explaining that 95% of the 5150 calls he got as an officer were drug-induced problems. While this was happening, another nurse, Ryan, walked into the intake room purposefully, moving his way around the officer and me. Ryan asked if Hector would cooperate. Hector, timidly, said he would. Ryan asked if Hector would stay in the hospital. Hector said he did not want to but would cooperate. Ryan's face turned slightly pink. "Did you hear that?" he asked his fellow nurse, "He said he wasn't going to cooperate." Surprised, I could not tell if this was a willful misunderstanding on Ryan's part or a matter of simply mishearing the patient. Ryan left the patient intake room to ask Dr. Banks to write an order for a "shot," an intermuscular injection of sedating medications. Having sensed something about the patient in her initial interview, something unsettling, Dr. Banks agreed.

Meanwhile, the police officer attempted to do damage control. He told Brian that the patient was cooperative 90% of the time and easy to calm down the rest of the time. Under Ryan's orders, a quiet room was emptied and the nurses walked with Hector back to the patient rooms. Upon realizing that he would be secluded, Hector paused. The last time he was here, he explained, bad stuff happened when they put him in that room. He did not want to go in. The nurses moved quickly, a "code gold" was called. The patrol unit of the sheriff's department arrived. Hector moved into the room and was given the shot. Now seated, he explained to Brian that he did not want to hurt himself or others, but the psychosis was overwhelming his senses.

Mimi, meanwhile, was the nurse responsible for another patient's—Brittany's—care. In the moments after the intake interview, Brittany had become increasingly agitated and attempted to disrobe. Mimi wanted a quiet room for her patient, but there were none available, because Hector had just been placed in the last one. The seclusion room elsewhere on the unit would have to work. Brian and Ryan were not far behind. Another shot was prepared for Brittany, and the nurses coaxed Brittany to lay down on her bed. "Don't rape me!" she shouted. Ryan shook his head in disdain. Walking down the hall toward the nurse station, Ryan commented later that it was "so typical;" Brittany had stripped her clothes off and then said don't rape me. I began to wonder about Ryan's relationship to the patients whom he treated. I felt that he had escalated the interaction with Hector, such that Hector was cast as dangerous and secluded from other patients in a room that had once been traumatizing for him. He seemed not to respect Brittany's vulnerability as a patient. In that moment, I realized that I did not like Ryan and suspected he did not like his patients.

Not long after, I found Ryan at a computer in the nurse station reading over the "Drudge Report." I sat down beside him. He did not minimize the website, and continued to scroll. I asked him how he became a nurse. Ryan explained that it was a bit of a winding road. He had wanted to be either a police officer, engineer or in the medical field after high school. He held a job as a certified nurse attendant for a while and discovered that there was money to be made as a nurse. He had been hired by the county as a relief nurse but before that had considered working as a jail or prison nurse, he explained. He had heard that it was pretty straightforward work at Twin Towers (a jail in Downtown Los Angeles), but then a friend asked him why he would want to work caring for the "trash of society." He agreed and took a job in the Psychiatric Emergency Room instead. But, he lamented, it turned out that he was caring for "pretty much" the same people. Most of the people who come in to the ER are not ill, he continued, but high on drugs, meth. I asked him if he considered addiction an illness. Ryan blinked. He supposed that was true, but marijuana, for instance was not addictive and still induced psychosis. Our conversation was interrupted when another nurse came in to ask for help. A new patient who had arrived was a "live wire," also suspected to have used methamphetamine.

In the hours that followed I found myself ruminating over Ryan's comments that patients in LAPH's Psych ER were the "trash of society." From my perspective, such a comment was an indictment of a society that would view anyone as disposable. Yet, I knew that Ryan did not mean it this way. Ryan was a part of that society and did not want to care for those who should be thrown away. Following his comment about the similarities between the hospital and jail population, Ryan makes a claim that the patients in the ER were not ill but high—a moral status that made them the trash of society, not deserving of care. Importantly, though Dr. Walsh estimated only 25% of the patients were under the influence of any drug, Ryan claims otherwise. The "methy mood," that reverberating sense of the "methy feel" had extended well beyond any given patient, covering the entire population with the stigma and criminalization associated with methamphetamine use.

Considered alongside the interviews conducted with Doctors Walsh and Torres, Ryan's observations and those of the police officer who brought Hector to the hospital reveal multiple dimensions entailed in a "methy mood" as it emerged over the course of my fieldwork in LAPH. It is useful to reconsider Dr. Walsh's observations about countertransference here where one's history of affective laden relationality shapes how patients are perceived such that there are those who may be the "trash of society" and those who are worthy of care. The repetition of a certain kind of patient experienced via a sense of cyclical movement through the hospital (i.e. The "revolving door," see Chapter One), in a situation in which prison and clinic are intimately linked through personal, political and infrastructural means, and where poverty, lack of shelter, drug use and abuse work to foreclose many possibilities for patients of LAPH.

Ryan's attitude stands in distinction from many held by nurses on the unit, who viewed their work as a matter of care for all. At the same time, it is representative in the extreme of comments that many clinicians made out of frustration or exhaustion in response to methamphetamine-use in the psychiatric patient population. One nurse joked after an interaction with a patient who admitted to using methamphetamine that such a patient would be "Duterte'd" (killed), if they were in the Philippines. Clinicians call upon their personal histories and orientations to drug use in everyday experience to navigate a mood about methamphetamine use that is variously depressed, resigned, frustrated and resentful. In the process, the "methy mood" becomes a mood of possibilities, albeit foreclosed possibilities for scope of patient care available to anyone suspected of MAP in the ER. The methy mood, characterized as it is by resentment and frustration, may drive many to a kind of certainty about the patient population regardless of the actual patient experience. Such a mood is a reminder about the risks that accompany various drives toward certainty in both diagnosing and treating patients who may (or may not) have used methamphetamine.

Left: Cleaned leather restraints hanging in plastic bags, ready for use. Right: vials of Haloperidol, Ativan, and Benadryl to be used in an emergency intermuscular injection.

FIELDNOTE THREE

Hospital, Prison, Jail:
Safety, Vigilance and Discipline at LAPH

July 2016

It was midsummer in Los Angeles, and June Gloom had crept into early July. Though the summer sun had cooked off the last of the clouds that morning, it was still fairly cool this evening, as the day shift attending physicians signed off to their night-shift counterparts. I had made plans with a senior resident to shadow her through the night. Doctor Maggie James was joined by another fourth-year resident, Amanda Seale, a medical student who would shadow the doctors for a few hours and an attending psychiatrist, Ron Oblonsky. Ron, a Russian immigrant in his in mid to late sixties, always seemed to wear the same light blue polyester shirt with a pointed collar and white, slightly flared pants whenever I saw him. It made Ron seem like a figure out of time or beyond time. Until that evening, I had struggled to imagine his life beyond the hospital, building an impression of Ron as somewhat stoic and curmudgeonly. Tonight, he would prove me wrong…at least partially.

It was a quiet night in the Psychiatric Emergency Room. The shift began with sixteen patients on the unit and three were transferred to inpatient units early in the evening. Early in the shift, I walked with Maggie down to the Cafeteria, where she ordered her dinner, a burger and fries. Along the way, she told me about her plans for the next few years. Her husband was considering going back to school for a Master's degree now that she was almost finished with her program. They were determined to stay in Southern California. She was considering ways she might get involved in telepsychiatry in the coming years. It was one way that she might have more flexibility in her work environment, she explained. We trekked back to the ER and the doctor's hub, where Maggie settled in to eat. As I was preparing to ask Maggie about her experiences of her resident practice, Ron entered and he began interviewing me.

Though we had met before, it was mostly as I was finishing the day shadowing someone on the day shift. While I prepared consent forms for Amanda and Ron, I explained that I was an anthropologist. Ron asked me if that meant studying the physical body and the evolution of human beings. I told him that was a subfield of anthropology but not my specialty and tried to direct him to the consent forms. The only thing he knew about anthropology, Ron said, was primatology. "What could be gained from studying monkeys?" he asked, laughing. As he read over and signed the forms, he continued to chat about primatology. I told him about the study of capuchin monkeys that had been carried on in my department for over 20 years. Ron quizzed me about the study, and I told him about the social greetings, games and bonding practices that were passed between groups of monkeys in much the same way that trends and cultural practices are among humans. Laughing, I told them about a video that I had seen of two monkeys engaging in a bonding ritual, their fingers up each other's noses until their eyes began watering.

With the consent form still in hand, Ron shifted the subject to psychotherapy. Realizing I would not be able to ask the questions I planned for Maggie, I did my best to open the conversation up between the four of us, a kind of group interview. Ron was annoyed by most psychiatrists and therapists who seemed to indulge patients' fantasies, he explained. He had a patient, for instance, who was placed on a hold, because she described fantasizing about cutting open someone's stomach. The patient, a young woman, was seeking attention Ron thought. The therapist who had put her on the hold legitimized her violent fantasies in a way that would encourage her to continue seeking that delusion, Ron explained. In his thick Russian accent, he told us that you cannot sit with your mouth open, gasping at these violent fantasies. You must challenge them. Ron briefly turned his attention to the computer before him, placing a few medical orders.

I asked Maggie what she thought about the ways that violence was associated with mental illness, the way it was talked about in response to the mass shootings that happened that year. It seemed to overwhelm the news that year, and my mind drifted to the active shooting that had occurred at UCLA only a month earlier. Maggie seemed a bit angered at the premise of my question, or perhaps the way I phrased it. Most of these acts were not a problem of just mental illness, she said. People with schizophrenia, she explained, are not organized enough to go to a church and shoot people. We were interrupted by a call, and she turned to the computer to finish reviewing notes on her patients. I sat for a moment in the silence, reflecting on the shooting at AME church a year earlier, the way violent actions were dismissed or explained away by mental illness.

Amanda spun around in her chair to face the group. She heard a podcast recently, Invisibilia, about the subject. A man had intrusive fantasies about cutting his wife's throat. She was brave enough to let him put a knife to her neck. HE couldn't go through with it and he eventually overcame the fantasies, she explained. Over the course of our night together, I would learn that Amanda was a generally curious person who marveled over social scientific discovery, having been raised by a sociologist. Her description of the podcast sparked Ron's interest again. Now finished with his notes he spun around in his chair to face us again and continued his rant about overly indulgent psychiatrists.

There were too many therapists who cause damage trying to be friends with their patients. It is a false friendship. You are not their friend, he explained. A bartender could do a better job than those psychiatrists. In fact, most bartenders do a better job than those psychiatrists. You pamper and baby a patient, then they leave your office a baby, he argued. A forty year old comes in very anxious about his bills which he has failed to pay. A psychiatrist who then goes ahead and pays the bills for him does him no favors. He enters a forty year old and leaves a ten year old. These psychiatrists, he tells me, gesturing in the air, are like monkeys with their patients' fingers in their noses.

Chuckling, I asked Ron why he chose psychiatry, then. While he practiced all types of medicine when he was in Russian, when he came to America, he decided he'd had enough with general medical practice and with the body. There were only three groups of disease in medicine: 1) a disease that you can treat and fix with treatments; 2) Chronic illness which you treat but which offers very little change; and 3) fatal diseases for which you can only offer palliative care. That's it, the sum of medicine, he said. Psychiatry was more complex and compelling. Knowing that Amanda was interested in child psychology, Ron shifted to ask her about a recent lecture that she attended. The psychiatrist who was lecturing really dove into questions with patients and was very psychodynamic and even challenged patients during interviews. For Ron, it was important to know the way that a question could frame a therapeutic encounter. It was easier to ask yes/no/I don’t know questions. I got the impression that Ron did not find long and meandering thoughts a particularly useful diagnostic when engaging patients. I wondered where the complexity in psychiatry lay for Ron but felt a very strong need to return my attention to Maggie, who, after all, was the doctor I was supposed to shadow that night.

I turned to ask Maggie about her approach when Ron interrupted. He looked at me and the medical student to my right who, until now had remained silent. Here is the “best joke about interpersonal relations,” he offered. “Can a woman make a man a millionaire?” The medical student, a young woman, looked at me and hesitated. Eventually, we both said that we did not know. Ron replied, “Sure she can, if he was a billionaire to begin with!” The best joke about interpersonal relations, he repeated.

Mercifully, Maggie chimed in and asked Amanda and me if we would like to see her dream project. She showed us a commercial of a pop-up pizza kitchen. Her dream project would look a lot like this pizza truck, a mobile telepsychiatry unit. On the right side would be televisions where patients could meet psychiatrists. In the middle would be educational resources and a nurses station and on the other side would be a pharmacy where patients could pick up their medications. She would start the mobile unit in Guyana where her parents were from. Navigating to a website about Guyanese mental health, she explained that the country had one of the highest rates of suicide in South America and only three psychiatrists. Amanda asked her why she thought the rate was so high. There was a lot of stigma related to mental health, Maggie explained, and a lot of prejudices about seeking help. I asked Maggie about her family. Her parents immigrated to the US long ago, but they visited Guyana still. She hoped to go back there some day and had already made contact with an NGO there, but it would have to wait until she and her family were more financially stable.

Amanda looked over the extra copy of the consent form that I had given her. She really admired Jo, the attending psychiatrist who was serving as the PI for my research at the hospital, she explained. She continued looking over the form. Her father, now retired, was doing sociological research on “charged” water and was somehow running his own IRB, she told me. Maggie held up her bottle of alkaline water from Trader Joes and asked Amanda if that was “charged” water. Amanda nodded slowly, something like that. Her dad had explained the science a million times, but she always forgot. They began talking about how chronic illness might drive people to chase anything that could offer comfort. There were only two waters in Russia, Ron chimed in, water and vodka. He showed Amanda a bottle of mineral water that he tried to drink regularly, and she took a picture to text her dad. I could not tell if she was actually interested, or if she was accommodating Ron. Dr. James and Dr. Seale agreed with Oblonsky on a lot of topics, though there often seemed to be some hesitancy, especially in his utilitarianist descriptions of psychiatric care. The young doctors were very diplomatic, it seemed.

After texting her dad, Amanda turned her chair more directly toward Ron. Without explicitly stating it, I got the impression that she had decided to join me in my study. Together, we began an impromptu life history interview with Ron. Born in Siberia, he made his way to Moscow, only to be excommunicated for reasons that were vague but apparently bureaucratic and confusing. He lived as a refugee in Austria, separated from his family, until he found a way to get back on his feet through a soviet refugee program. Dr. Seale was flabbergasted and continued to probe. I got the impression that many of the resident doctors did not know Dr.

Oblonsky very well. In the early 90s, Ron continued, he made his way to the US, took his exams and began his residency at LAPH. Though he worked primarily at LAPH, he had also held a position as a psychiatrist in a jail facility. This year marked twenty years at LAPH. I asked him if he had been able to see his family since he arrived in the US. He shrugged. Amanda, now keenly invested, asked him about the adjustment to the US, commenting that it must have been very hard. Ron shrugged this off as well. It was just what it was, he said.

We chatted for a while about the way psychiatric emergency practice had changed over the years and then, personally, how the practice had changed for each of the doctors. At the beginning of her residency, most people in the hospital was very hesitant to dismiss any person who arrived already under a 5150, but a few new attending doctors had changed the approach. Amanda learned it was okay to discharge patients, and her confidence as a doctor steadily grew. I asked her how that confidence manifest. She explained that she was less afraid of people with mental disorders now, even outside the ER and was more aware of the links between mental illness and homelessness. You have to put your safety on the front page with a psychiatric patient, Ron explained. But that wasn’t so much the case with medical students, he nodded to the student before him, perhaps to comfort her. I asked how they knew if it was ok to release a patient.

Well, if they show up with luggage, Dr. James joked. Amanda and Ron laughed. Yes, that was generally an indicator that they were not quite emergent or even urgent cases. Perhaps just a person seeking shelter. “You just kind of get the hang of it,” Maggie shrugged. Amanda nodded but offered a caveat. IF the patients say the right words, you have to admit them, even if you don’t think they are likely to hurt themselves or others. There is also liability to consider.

Ron pushed back. If you release a patient, and they walk out and are hit by a car you might be culpable in some ways, but you can't be afraid of that.

The conversation waxed and waned, and soon we were discussing how the doctors found ways to cope at the end of the day. Ron had a few beers and watched TV. Maggie had started her own line of soaps and lotions. She showed me her favorite soap making website. She asked me about my hobbies and, noting the many vats required for soap making, I comment that I once made wine. Our conversation drifted to other forms of fermentation and eventually to "hooch." Ron interrupted us. In prison, he explained, it is not called "hooch," but "pruno." In the midst of our conversation, Mimi, a nurse entered the doctors hub. One of her patients, Ricki, was becoming agitated and would likely need an IM, she explained. Dr. Seale looked at the patient's record and remembered that an attending on the day shift had warned this might be a troubling case. Amanda would first have to interview the patient. I joined, following her to the patient area.

By the time we arrived, Ricki, the patient of concern, had exited the patient rooms and was in the hallway, standing between the nurses station and the quiet rooms. He had tried to exit through the emergency exit door but found the weighted door to be too heavy and had focused his attention instead on the entrance to the patient rooms. He raised his arms and did a few lunging jumps toward the nurses and nurse attendants who were surrounding him. Then, he made a run for the other entrance. Amanda ducked quickly out of the way and into the nurses station. I tried to back out of the way, and slammed my spine against the corner of the hallway leading to another patient room. Wincing, I moved quickly to an area where I knew I could give the nursing staff space while I shook off the shame that I felt, having forgotten to notice where I placed myself on the unit. In this new position, I could see Amanda's hands shaking behind her back.

The nurse attendants scrambled to surround the patient again, while Dr. Seale requested a code to be called. As Ricki was distracted by the nurse attendants before him, another came from behind and wrapped his arms around the patient and behind his neck in a kind of hold. It did not work. Ricki began slipping downward and out of the nurse attendant's grasp. "Grab his legs! Grab his legs," another person ordered. They attempted to catch hold of Ricki's legs as he kept kicking. The group moved chaotically backward toward the emergency exit but, finally, managed to lower Ricki to the ground and restrain his limbs. One hand slipped free and hit a nurse attendant in the eye. As their colleagues worked to catch hold of the patient, two nurse attendants had prepared to restrain Ricki in bed, one approached with leather restraints while another replaced the linens on a bed in a quiet room. A doorbell sound rang out over the intercom "Code Green in the Psychiatric Emergency Department. Code Green in the Psychiatric Emergency Department."

For a moment, Amanda stood, staring blankly from her spot in the nurses station. Then, she shook herself out of it, shaking her hands and head as if to shake herself back into work. She navigated to one of the computers facing the quiet rooms. With her attention on the patient and the computer screen, she began to make the order for an emergency injection. Finished typing in the orders specific to the patient, making clear that the order was for immediate use, Amanda shook her hands again.

The nursing staff successfully placed leather cuffs on the patients arms and legs. Ricki continued to resist as they slipped leather straps into slots on the cuffs. He kicked with his whole body while the staff surrounded him on each side, lifted and carried him into the quiet room. Eventually, the nursing staff was able to restrain Ricki, hooking leather straps to spots on the bed specially designed for such purposes and placing another strap around his waist. The patrolling Sheriff's deputies arrived. Code Green was the wrong code to call, they told Amanda. That should only be called if a patient actually leaves the building. This was a “Code Gold” for behavioral problems. As Amanda nodded along, repairing her mistake, the nurse attendant who had been hit entered the nurses station in a daze, a red lump growing just under his right eye. After making sure no one else was hurt, Amanda let Mimi know that an order for an injection had been made. The officers, meanwhile, began filling out paperwork. Dr. Seale left to begin writing her note on the restraint. As we exited the patient area, she shook her head. They were really lucky as doctors, she said, to not be on the frontlines the same way that nurses and nurse attendants are. When we reached the doctors hub, Maggie and Ron were just springing into action. Four patients had been brought to the ER at once, and one was already agitated.

Maggie prepared the necessary forms for admitting a patient on a 5150, including medical consent and firearms prohibition (every patient placed on a 5150 loses the right to possess firearms for five years). She noted that the patient was in handcuffs and would not be able to sign the documents yet but would be advised of them. On the backside of a copy of the patient’s 5150, Maggie mapped out a few areas for her interview: RX (Was the patient already on medications?), PSI (Did the patient express any suicidal ideation?), ALL (Did the patient have any allergies?) and Collateral/Fx (additional information that she might glean from family members and anything she might gather about family history). We went to see the patient, Alexi, who had been brought into the hospital by a Mental Evaluation Team (MET), comprised of one police officer and one social worker. I was not able to get the patient’s consent to observe the interview but took note of the ways that the police officer and social worker kept redirecting the patient, prompting him to describe his medical history the way he had when he was in the police car. After the interview, the police officer stopped Maggie before she could return to the doctor’s hub. He thought that the patient had not effectively answered the questions. It seemed to him that the patient was responding to internal stimuli while they were in the car—his eyes fluttering, his mouth moving. The patient was not violent but had been argumentative and angry and possibly had hurt his mother during the altercation that brought him to police attention. We headed back to the office, but Maggie stopped herself. She had forgotten the medication consent and firearms prohibition. She returned and was greeted by Lucia, the nurse assigned to Alexi's case. Lucia asked if Dr. James was considering an injection for the patient. Maggie said that she thought she'd like to see if the patient could take medications by mouth first, but Lucia pushed back. It would be easier and more effective just to give the patient an injection. Maggie conceded.

When we arrived back in the office, Dr. Seale was listening to a triage report from the charge nurse. The prospective patient was a young man who wanted to undergo a detox for methamphetamine. He was presently high but expressed no suicidal ideation or homicidal ideation. "Did the nurse consider it urgent?," Amanda asked. The nurse replied that she didn't, but that the patient's girlfriend was insisting that he be seen and would not leave without a consultation. Well, Amanda explained, we have a lot of patients at the moment, and it is not likely we will admit this patient. If the patient was seeking help for substance abuse disorder and was not in a state of psychosis or crisis, he was not a patient appropriate for the Psych ER. She suggested that the nurse advise him of that. Amanda rushed out to attend to another patient, while Maggie sat down to enter notes on the patient she'd just seen. Her shift would end soon (she was not the on-call resident for that night), but she thought she would be able to see at least one more patient.

Maggie drew up a medical notes template that an attending psychiatrist had created and followed each prompt noting the patient's psychiatric symptoms, medical symptoms, appearance, and orientation. She completed a suicide risk assessment. Made a temporary diagnosis (necessary for Medicaid coverage) and outlined an assessment and plan of care for the patient for the evening, recommending the patient be transferred to an acute psychiatric care facility for continued care. As she was writing, Amanda returned, breathing quickly as if she had been running. "Shots all around!," she said. She remained standing, placing one hand on her hip, as she navigated through the hospital's system to place an order for an emergency injectable medication. Not like gun shots, she clarified, shot shots. Her patient had just been divorced and lost her kids and was now acting very agitated, she explained. We have a lot of sick patients she sighed, almost to herself.

Maggie was able to finish her notes and attend to one more patient, a very depressed woman who had been brought in by police after threatening suicide. Maggie thought that she had been seeking attention and did not have an illness but later wrote "adjustment disorder" as a diagnosis. For insurance purposes, she explained. The rush of patients having ebbed somewhat, Maggie signed off, telling Amanda that she had nothing in particular to report about her patients. It was just past midnight, a little later than Maggie had hoped.

December 2016

It was a couple weeks before Christmas. I arrived at LAPH just before 7 am to observe nurses rounds during the shift change. The multi-purpose room in the inpatient unit had recently been decorated by the occupational therapy team and their patients. Green trees, red wishes for a Merry Christmas, paper snowflakes and snowmen. The nurses gathered around to review patient progress over the night and receive their assignments for the day. I sat down next to Max, a day-shift nurse who I would be shadowing. Max was kind, always willing to help me find my way when I first began work on the inpatient unit. The nurses rounds went quickly that day and Max began his work quickly. There was a lot to do. In addition to the five patients he was directly responsible for, he had to supervise the work nurse attendants were doing with an additional five patients.

First things first, Max had paperwork to complete. One of his patients was on the way to Department 95, the mental health court, to challenge his involuntary commitment. Max had to complete a form called “denial of rights” because the patient would be wearing hobbles—leather cuffs at the ankles, linked loosely by a leather strap to keep the patient from running away. Max also had to complete transfer papers. Once completed, he had to review his own patients. He made sure that the nurse attendants who would be checking over patients in the ward did so every 15 minutes for his patients. Some people were a bit more lenient, signing off on head checks every 30 minutes, but Max liked to be careful. These patients were still acute, he reminded me. Then, we went to visit Max’s patients.

The first patient, Ryan, was a quiet young man, phenotypically white, I had met him earlier in the week when shadowing an attending Doctor on the Unit. The next, Jerry, was Black man in his 70s who had urinated on himself. Max asked him to shower, but Jerry brushed it off. He would after lunch. After checking the patients’ orientations, vitals and medication needs, Max moved on to the next. In the hallway, he told me that Jerry had done this sort of thing a lot. Max would ask Jerry to shower after lunch and Jerry would push it back until after dinner. We found Max’s third patient, Mario, asleep on one of the couches in the “Day room,” which was really more like a wide hallway filled with a few heavy plastic chairs, a TV mounted in one corner. Mario, a middle-aged Latinx man with tattoos running down the length of both arms, held one arm over his head and looked up at us. He smiled, but seemed sleepy. Max did not want to discourage him from sleeping, and kept the check-in short. Mario had apparently not slept well the night before, his roommate had been difficult. The fourth patient, Louis, was still asleep. The final patient was Jaime, a young man who had been diagnosed with autism and was considered non-verbal.[38]

We returned to the nurses station to review medication orders and documentation from the night before. Max looked carefully over the medication documentation for Mario. This patient, Max told me, was a bit hyper, so he wanted to see if the doctor had prescribed any PRNs (as-needed medications). Curious, I asked Max what he meant. Hyper? Yesterday, Max explained, the patient had been hyper vigilant. You have to look out for hyper patients, he continued, because they can start a chain reaction and then the whole ward is on edge. When patients start acting out, the others support each other. The patients overall are less acute than in the ER, he explained, but they are still very acute. This patient in particular had a kind of jail mentality, coming from jail. He had sort of a suspicion about others and could be on edge, a problem if they wanted to keep the unit calm.

Max continued to look over the medications and notes. Ryan would be discharged either today or tomorrow. Louis, the patient still sleeping, apparently had a few legal charges against him and restraining orders but had not acknowledged them. Finally, Max pointed out, Mario had tried to smoke yesterday and escape from the hospital. He'd tried to elope from the ER, Max reiterated. Mario would have to be carefully watched. He turned to collect medications from the Pyxis, a machine which fingerprinted each nurse before dolling out their requested medications. Noticing a long line of nurses waiting to access medications for their patients, he decided to

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[38] Due to the complications of this case, I was unable to receive consent from the patient. This was further complicated by the patient's status as an undocumented immigrant with apparently no familial connections in the US. The institutional responsibility for the patient's care was unclear. The multiple levels of vulnerability here, mean that as a researcher, I cannot disclose further information about his status or his care.

finish his shift assessment notes—how he first encountered the patients—and look over the treatment plan the doctors had outlined for each patient. As he was reviewing his notes, a nurse attendant, Layla, who would be accompanying Max's patient to court walked slowly over to us. As she spoke, Layla casually pulled apart the restraints which would be used for the patient as hobbles, unhooking the leather cuffs to be wiped down. Don't touch those with your bare hands, Max warned. Another nurse attendant in the station laughed and chimed in, yeah, don't want to touch those and then eat right after. As they were talking, I remembered how the ER staff had described the inpatient unit as generally dirtier, as patients with poor hygiene stayed much longer than those who cycled through the emergency unit. Layla shrugged, "I can wash my hands."

When the line for the Pyxis had cleared, I followed Max into the medication room, a small locked closet inside the nurses station. The chief difference between the ER and the inpatient unit, he explained was that they did not see patients in the ER for very long. Lots of cycling in and out. The acuity of illness is higher in the ER, but it is still fairly high here, he explained, evoking his earlier decision to keep patients on 15 minute intervals for head check sin the unit. Many of the patients who ended up in the inpatient unit were gravely disabled. Nobody wants the "GD" patients, he noted. Indeed, during my time shadowing case managers in the ER I had learned that patients deemed gravely disabled were harder to place in other facilities as they were assumed to be in such acute states of illness that they would require much longer treatment, taking up beds and resources that could be used for other patients.

Max went back to his desk to double check that each medication he pulled was correct, emptying the pills into small condiment cups—one for each patient—as he checked and then placing the cups in a tray with sections marked for each patient. We woke Louis up and Max completed his initial morning assessment before handing the patient his pills. I noticed as Louis chewed his medications and then washed them down with a cup of water. As we left, Max asked me if I noticed this. Chewing the medication increased the effect of it, sped it up. This patient was “a little bit drug seeking,” he conjectured. We found Mario in the day room. As I watched Max deliver Mario’s medication, I took time to notice the patient a little more. His face was very angular. His eyes seemed sunken, tired. Mario smiled, and chatted to us for a while, as Max delivered medications, leaving the patient with a packet of bacitracin for cellulitis the patient had sought treatment for in the Medical Emergency Department. Leaving, I reflected that Mario did not seem to be the kind of patient to try to elope, at least not at that moment. I considered the way patient behavior can change so quickly over the course of a few days.

Back in the nurses station, I took a seat a little distanced from Max’s computer to watch the nurses at work and listen as one of the attending physicians, Dr. Li, prepared his team for the court case today. As I was wondering what color the walls were painted (I settled on “avocado”), a nurse laughed and drew everyone’s attention to a patient just on the other side of the station’s plexiglass windows. “Look at Dolly, she’s got a smile on her face.” Dolly was watching the nurses at work. After forty-five days in the hospital, she was going to be transferred to a state hospital. Her bags, a small sequined backpack and several clear hospital bags, were stacked on a chair in the station, ready for transfer. Another patient, meanwhile, began knocking urgently on the window. She wanted to talk to Dr. Li but she wasn’t his patient. “Pay me more,” he joked, and I’ll go see her. He opened the station door to speak with the patient and directed her to wait for her doctor, but she returned a few moments later and continued to knock.

As Max continued his work, a doorbell sound rang out over the intercoms. A “code gold,” a behavioral health emergency, had been called in the Psychiatric Emergency Room. Max was part of the inpatient back up team for Code Golds, so he signed off on his work and I joined him in the walk to the Psych ER. Max knew who the patient was before we arrived. I asked how and he explained this patient had come to the hospital multiple times already and had given them some trouble on this most recent visit. We walked in the ER through the backdoor past the breakroom where they were having a Christmas party. A few members of the staff were there eating pizza and other food from a potluck style lunch. They asked us to join, but Max told them he had a Code Gold to attend to first.

Dr. Bill Walsh was standing before the patient in one of the quiet rooms. Walsh had dressed for the Christmas party with a red Christmas-themed t-shirt over his usual button up dress shirt. Dr. Salid, a resident in a red and white snowflake sweater, leaned against a wall just behind Dr. Walsh, looking up at the patient occasionally and then down at the floor. The patient, Mark, was standing in front of his bed. He was a very tall, broad shouldered Black man in his late 20s or early 30s with tattoos across his chest, arms and legs. He had already been partially restrained, with leather cuffs around his ankles and wrists. Several nurses from the Psych ER had formed a circle around Mark and Max joined in. Bill, meanwhile, tried to convince Mark to have a seat on his bed but Mark refused. He wanted to take a shower.

Not long after, the sheriff's arrived. Mark seemed willing to talk to one of them, a young woman. He asked the sheriff's to arrest him. The hospital was worse than jail, he said. He spit on the floor near one of the nurses and yelled at Max who he recognized from a previous encounter in the ER. He spit toward one of the sheriff's, a bigger man. One of the nurses told me to move and I did. Stepping back, I watched as one of the deputies removed a taser from her belt. She prepared to point it at Mark but stopped. Eventually, the nursing staff were able to talk Mark into sitting on his bed. He did. They asked him to lay down. He did. Though he asked not to be restrained, they completed the process tying the cuffs to hooks on the end and middle of the bed for his legs and arms. They gave him an intermuscular injection. The doctors, meanwhile, had moved into the hallway and watched as Mark was restrained through the quiet room window. Bill turned toward me and said that this was exactly how it should always go, but sometimes they don't have the time or the circumstances aren't right or they can't talk the patient down. Yesterday, he explained, the nursing staff had to pin the very same patient down on the ground because he was fighting back. Meanwhile, the doctors had been trying to work with Mark's family.

After a short stop in the break room for some Christmas pizza, Max and I headed back to the nurses station in the inpatient unit. Dr. Lauren Walton, the chair of the inpatient unit, met me there and asked if I would like to observe an interview with a new patient. I joined her and medical student in the patient's room where she was lying on her bed. Walton asked if we could go somewhere to talk privately and the patient agreed. Xochi was a young Latinx woman with long black hair that had been tangled into one thick, matted knot. Two long strands of hair hung down on either side of her head. We walked to a small interview room at the center of the inpatient unit. Once seated, Dr. Walton began to take down the patient's medical history.

Xochi had come to the ER a few months earlier. In the time between, she had been arrested and taken to jail. It was unclear what had happened in jail. The charges had been dropped or else the patient had not been restored to competence in the time allotted and was released from jail. The sheriff's department, who run the jail facilities, determined she should not be released and brought her to LAPH instead. Xochi denied the charges against her and the idea that she needed to be hospitalized. Dr. Walton asked if Xochi had family or friends who could be contacted. They might be able to help her get out of the hospital. Xochi shook her head. It was useless. She ignored the doctor's repeated requests and grew quiet. Dr. Walton ended the interview and directed Xochi back to her room. Once there, she called back to the Doctor and agreed to give contact information for the patient. I followed Dr. Walton and the medical student back to the offices just outside the locked, inpatient unit. After a few short moments discussing next steps in patient care—writing the medical note, contacting family—I dismissed myself and returned to the inpatient unit to find Max.

Dolly was still pacing in front of the windows at the nurses station, when I returned. “ I guess Dolly is just going to star at us until she leaves,” Isabelle, a nurse attendant shrugged. She is going to go home though, Isabelle continued, “good for her” Sitting in the nurses station was a little like being in a fishbowl, I joked. Isabelle agreed. She had learned a lot from the patients, but “They’re better at reading us than we are them,” she continued. Being “from the streets,” patients had to learn how to read people. So, she continued, you have to be careful not to be manipulated. As we were talking, Max left to go relieve a nurse attendant who was sitting 1:1 with a patient. I followed him into the hall, where he sat just outside a seclusion room where the patient was resting, the door open. Several patients were walking the hall. One of the patients, smiled and waved at me. I paused and then waved back. He smiled, waved again. I paused and waved back. Another patient, came into the hall. He saw me waving and then waved at me too. I paused and waved back. The first waving patient smiled. Max, who had been watching all of this laughed. See? he said, a chain reaction.

CHAPTER THREE

Vigilance and the Jail Mentality:
Safety, Care, and the Signification of Danger

Every morning at around 7:00am, the nurses in the psychiatric inpatient unit at LAPH began their shift with a report from the night staff. This morning, after being stuck in traffic, I arrived a bit late along with a few nurses who had been in the same highway tangle. A nurse attendant was in the midst of her report, and others in the room were unusually quiet and still. I sensed a tension, but did not yet know why. The night before, the nurse attendant reported, she found a wire—a paperclip bent out of shape. One of her patients, John,[39] had been using it to manipulate the security light switch in his room, turning the lights on and off. She was able to confiscate it. After a brief speculative debate about how the patient got hold of a paperclip (an object banned from the unit), Esther, the nurse supervisor called out shift assignments. Then, she dismissed her staff with a warning. Do whatever it takes today, she told them. Use IMs (intermuscular injectable medications) or PRNs (as needed medications) whenever. *Stay safe.*

As everyone began to depart, I caught up with Max, a nurse on the unit, to ask what was happening. Max, a good humored and patient man who had been working for several years there was my go-to-source when I needed guidance in understanding the procedures and practices on the unit. The day and night before, he explained, an apparent gang rivalry had developed between several other patients on the unit and John. “Black versus Hispanic, maybe,” Max offered. He moved on quickly to begin his morning rounds, checking in with each patient he was assigned. Meanwhile, I found myself caught up in the anxious excitement that continued to bubble among medical staff in the nurse station. The Chair of the Psychiatric Department, Dr.

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[39] In addition to using a pseudonym here, to protect identity of the patients involved, key biographical features are composites of more than one person.

Nowak, arrived for a routine morning check-in. Esther showed him a picture of toothbrushes that the other patients had sharpened into possible weapons or “shanks” and the paperclip John had been using to turn the lights off in his room. It seemed to be a “Hispanic versus Black thing,” she offered. She showed me the photo of the toothbrushes and the unwound paperclip on her phone. As Dr. Nowak and Esther were talking, a doorbell sound rang out on the intercoms throughout the hospital. A “code gold,” a behavioral health incident, had been called in the inpatient psychiatric unit.

Max quickly entered the nurses’ station. John, now Max’s patient, was apparently still agitated after the contraband search the night before. He threatened Max with physical harm. Max and Marcus, another nurse on staff, determined that John would need an intervention and had called the code. While a few nursing staff began to put on gloves, prepare the emergency IM and leather straps for physical restraint, other nurses arrived from the Psych ER as back-up. Deputies from the LA Sheriff’s Department hospital patrol unit were not too far behind. Law enforcement officers are required to be present for all “code gold” interventions for observation but are prohibited from physically touching the patient. Their presence, I was told by several doctors, had a subduing effect on agitated patients. I moved into the hallway as those in the nurse station sprang into action.

As restraints were prepared, while John was physically restrained and sedated and in the hours after, several observations were made about the patient by onlooking deputies, staff and clinicians. His behavior was “straight-up street stuff,” a deputy explained. John had a “jail” or “inmate mentality,” I was told. Eventually, one of the deputies pointed his taser at the patient, aiming the laser guide directly at John’s chest, a potentially deadly shot. Despite this explicit commentary, despite the drawing of the taser, the restraint went according to procedure and was documented as such. Yet, the raced narratives about the patient (i.e. “Black versus Hispanic”) and the mood of stress and threat that preceded and followed it made this a particularly striking event when compared to the many other instances of physical restraint observed over the course of my fieldwork. For weeks after, clinicians and the nursing staff in particular would refer to these weeks when patients with “jail mentality” (John and the others with whom he had a “rivalry”) as uncommonly stressful and unsettling. This seemed to influence the ways that nurses and Max especially related to the patient population. Though he had in previous months recognized another patient with “jail mentality” in passing, now it seemed to be a more pronounced concern. I took this event to be a breach, then, that could be and in fact was particularly revealing about the assumptions of safety, danger and the function of the hospital as space for care versus space for incarceration that undergird much of the practices that occur on the unit every day. Particularly, this moment began to show me how vigilant logics of safety were developed not only in relation to institutional practice but to cultural experience that informed how clinicians came to behave in the unit and how they saw their patients.

During a quiet moment a few weeks later, Max and I sat down for a brief interview. As a practice with all my interviews, I asked Max (who spoke English as a second language) to describe a patient’s trajectory through the mental health care system. “They come here. We give them meds. They get discharged back through the same trap,” he explained. “After a few months, or six months, or a year—same cycle. It’s the same cycle repeats itself.[40]” “Most of the population you see here,” he continued, “They’re just former patients.” Then, he paused. “Right now, it’s increasingly the majority from the jail population.” I asked Max if there was a

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[40] For discussion on the cycle of patients through LAPH, see Chapter One.

difference between those patients who were from the jail population and the rest of the patients with whom he worked. He explained:

> **Max:** People who get into-into the jail system, often they have a jail mentality, so when they come to the hospital, they think hospital is a jail, too. They think the same way, which most of the time causes them to get in restraints, get injections.
> **Abby:** So, what. I-I think—
> **Max:** There, more-more violence on the unit.
> **Abby:** hmm
> **Max:** They-they fight with other patients. They think-they have a jail mentality so that's (Five second pause) like if-if that's their room, that's their cell, basically [laughs] (Four second pause)
> **Abby:** So jail mentality is—it includes more violence and they see the unit as a jail?
> **Max:** As a jail, yeah. Yes.

Max, like several others I interviewed, saw a change in the population. Some attributed this change to the California Prison Realignment (Discussed below; See also Fieldnote 1, page 2). Others like Dr. Nowak, however, argued that there had always been a circulation of patients between the hospital and jail system. Both perspectives are accurate. LA County has long been the nation's largest jail system and, on any given day, treats around 4,000 people incarcerated with mental disorders. It was not uncommon at the time that I interviewed Max for people to be released from jail without follow-up care and to then enter a state of mental crises (See Chapter 1) . Yet, there were also newer contributions to this critical flow between the jail and the hospital. After finding the conditions for mental health and medical health care to be dangerously inadequate and noting the overpopulation of California's jails, in 2011 the US Supreme Court found current carceral practices in the state amounted to cruel and unusual punishment, especially for those who sought health care while incarcerated (*Brown, et al. v Plata, et al.,* 563 US 493 [2011]). In response, California was tasked with dramatically reducing the prison population, releasing many without the structures in place for them to receive adequate care.

Without those services in place, it stands to reason that those with serious mental disorders, like John, might find themselves in a state of crisis and in need of care.

John, a Black man in his early thirties, was, like many patients who came to LAPH, brought in by police. While he claimed to have been incarcerated in the past, the hospital had no record of his criminal history. During his time incarcerated, John stated that he had been diagnosed with psychotic and mood disorders. For some who have been incarcerated or who have had loved ones incarcerated (as I have), "jail mentality" speaks to histories of repeated traumatic interaction with the carceral system and the inadequate mental healthcare provided (Dorotik 2011). For others, like Max, however, John's "jail" or "inmate mentality" belied a propensity for violence and an incapacity to recognize the hospital space as a space for care, a kind of particularly dangerous impaired insight. Indeed, when discussing John's medications with Max later that day, a resident psychiatrist noted that a police officer on the unit had warned her of John's "inmate mentality" and that stabbing was "their mode of operation." She warned Max to be careful, before they both discussed the possibility that John could be "cheeking" his medication. They hadn't seemed to have much of an effect on his symptoms. She concluded that she would need to consider medications that could not be cheeked or thrown up.

There is much at work, then, in the narrative about the function and operation of "jail mentality" as it presents on the unit. As "jail mentality" a patient's histories of interaction with the carceral system are pathologized and generalized. Such patients are then seen as potentially violent and untrustworthy, leading in this case for a reconsideration of not only how the patient is approached on the unit but also how medication is delivered. Such suspicions and practices are justified through logics of safety that inform hospital policy and practice. Underlying the identification of threat and jail mentality are safety logics and the vigilant stances they demand.

By virtue of limited resources including space, time, and staff for treatment, “safety” operates as the primary priority in emergency psychiatric care at LAPH. As *the* priority, safety is practiced and emphasized through the development and maintenance of embodied and performative vigilance. In the process, popular political sentiment and intersecting institutional ideologies are mediated through vigilant practice and logics of safety. In the case described here, the cycling of patients and professionals through medical and penal institutions and the operation of sheriff patrol units on the hospital inform a particular vigilant “professional vision” (Goodwin 1994) that makes “jail” or “inmate mentality” visible and recognizable in the behaviors of a particular patient. In this instance, the atmosphere of generalized danger and responses to it discloses a relationship between jail and prison systems in California and the hospital system and the explicit ways that the interaction of people and ideologies between systems (i.e. “Black versus Hispanic” and who is said to have a “jail mentality”) produce and perpetuate structures of inequality in care.

As calls grow for a deeper awareness for clinical practitioners of their roles in broader structures and systems of inequality, so too has the scholarship on the ways that these phenomena are reproduced in everyday mental health care practice (Metzl 2012, Metzl and Hansen 2014) . For instance, in her powerful work on the interrelation of psychiatric practice, managed care, and biomedical framings of mental illness and substance abuse disorder, Helena Hansen (2019) demonstrates how a “diagnostic apartheid” along race and class lines has become part of psychiatric practice. Exploring how psychiatric practice itself can be a determinant of health, Hansen shows the critical and nuanced ways that institutional and cultural logics of care may demand one diagnosis (e.g. Schizophrenia not Substance Abuse Disorder) so that those patients of color with limited means may become eligible for governmental support, while similar logics may allow white and middle class patients to evade stigma associated with some disorders and gain access to private support through alternative diagnoses (e.g. Substance Abuse Disorder not Schizophrenia). Drawing upon the racialized and classed histories of psychiatric care and the cultural capital of diagnoses, Hansen illuminates how institutional practice has been built to distinguish mental health care from addiction recovery despite the ways these medical phenomena frequently overlap and inform each other. This institutionalized distinction between forms of care operate as a key space where institutional racism may reproduce itself and also serves to limit both access to care and the moral agency of patients as they seek to navigate and narrate their own journeys through the health care system (cf. Myers 2016, 2017).

Acknowledging the ways in which race and class divides have been systematically institutionalized and reproduced in public psychiatric diagnostic practice, my goal in this chapter is to examine how these phenomena emerge to dangerous ends in the enactment of safety logics on the unit though vigilant dispositions. Exploring an instance where the interrelation of institutions is particularly marked, I explore how cultural, institutional and political ideologies are mediated through such vigilant dispositions. In the process, I show how embodied mediation of these ideologies makes it possible and even ethical for “safety” to become conflated with “care” in emergency psychiatric practice and the consequences this may have for patient care. Here, the conflation of care and safety is incomplete. Safety is a prerequisite for clinicians to do their work, thus providing a space for “care” to be possible at all (e.g. a patient is restrained to insure a clinician can safely administer sedative medications). Next, safety is considered care itself where restraining a patient ensures that they do not harm themselves or others. Yet, this logic does not include considerations for vulnerability of the patient while being restrained, a tactic that has been shown to have very negative repercussions for patient care itself. Finally, safety as care is cast in opposition to danger where danger may be variously typified in raced and classed ways that have significant repercussions for who may be worthy of such "safety/care."

The Single and The Multiple: Narrative Power and Justice in Theory and Practice

> "So, that is how to create a single story, show a people as one thing, as only one thing, over and over again and that is what they become. . .It is impossible to talk about the single story without talking about power. . .Power is the ability not just to tell the story of another person, but to make it the definitive story of that person."
>
> – Chimamanda Ngozi Adichie, "The Danger of a Single Story

There are limits to the endeavor undertaken in this chapter. In the ethnographic narratives woven throughout, I walk a thin representational line: I seek to honor the lives and work of both the patient and the caretakers working on the frontlines of an emergency system that is deeply under-resourced and underfunded, such that small units with many patients make the perception and risk of physical threat very real. This chapter captures events and reflections on a single day in the complicated lives of hospital workers and their patients. The goal here is to understand how particular events such as those described here can speak to—in all their singularity—the implicit ideologies and orientations to the institutional world in which these events occur and how such ideologies and orientations inform safety and care, generally, as taken-for-granted practices on the unit.

From the perspective of a singular event, an individual moment, every step taken to secure safety on the unit has merit, is justified, makes implicit and intuitive sense. Of course, on a unit where professional caretakers have sustained serious and even life-threatening injuries, responding quickly to the threats a patient makes are sensible. In a small unit that is dependent upon the maintenance of calm for both its operations and for stabilizing other patients, the response is very reasonable. It is only when considering the overarching historical and institutional constitution of such an event that this logic becomes tenuous, revealing patterns in how, when, and why danger is identified and on whose body such danger is localized. Indeed, from a phenomenological perspective, institutional, cultural and economic logics have sedimented such that acute psychiatric care in LAPH has been restricted to small, locked units which are themselves jail like. In such a constrained environment, even well-meaning doctors and nurses may find themselves seeing the space like a jail and those within as inmates (to be discussed below).

There are risks in ethnographic representation of such a restricted space in a restricted moment of time. In the years that have followed the singular event in focus, I have sat uncomfortably with the process of describing and discussing how I was able to witness and document it, the limits of my own perspective, and the consequences this account may have for how others understand both caretakers and the patient in question. These discomforts emerge particularly when considering the limits of information to which I had access during the course of the day and in my fieldwork broadly. While I was able to interview clinicians and law enforcement professionals involved in this particular moment of restraint, I was not able to speak to the patient, who was physically restrained and sedated. In the days that followed, John, like two others over the course of my time conducting fieldwork was arrested on the unit, charged with a crime and taken to jail. Limits of time and research resources meant that I was not able to be present for the day in which John was arrested, and constraints on the purview of institutional research oversight have further complicated the process of seeking his perspective into the experience[41]. My efforts along these lines are ongoing. This chapter, then, represents the beginning of a longer research process for understanding and contextualizing the events in

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[41] The methods and ethical quandaries presented in conducting research in an emergency psychiatric setting are discussed further in the introduction to my dissertation.

question and, ultimately, to bring the policies and practices of the hospital which justify police presence in psychiatric units, allow tasers in the hospital, and reinforce the process by which patients, particularly Black patients and patients of color, are criminalized in times of distress and subject to incarceration.

By now, cultural anthropologists know all too well (or should know) the power and thus danger of representation in ethnographic work. Since its inception ethnography has been used to justify colonial projects and dangerous often discriminatory legislation. Indeed, ethnography itself in its focus on the (often marginalized) "other" walks the "thin line between witness and spectator (Hartman 1997, 19). Even the most well intentioned white author, even white abolitionists (as I identify), have the tendency to exploit "the vulnerability of the captive body as a vessel for the uses, thoughts, and feelings of others" (ibid). In the US, reproducing violent scenes against Black bodies that mirrors much of the police and extrajudicial violence that has occurred over the course of this country's history, even while it is done in the name of care, may risk rendering "expected" the symbolic and real violence that occurs in the moments before, during, and after John's restraint (cf. Shange 2019).

Yet, while the ethnographic genre has been used historically to justify colonial practice and discriminatory legislation, it may also be used from a critically engaged perspective to turn the power of narrative representation on its head, to unsettle legacies of colonialism and open new possibilities for understanding human being as a pluralist, complicated and capacious form of existence (See for Instance: Speed 2006). While restricting my account so as to minimize the spectacle of psychiatric restraint which has been all too often spectacularized especially when used on Black bodies (See Rosenberg 2020, for an uncritical and spectacularized account of restraint), my hope is to turn the narrative on its head, to look instead at the unexamined assumptions and behaviors of police officers and clinicians which restrict who is worthy for care and how such care should be enacted. In this way, I hope to engage what remains expected and assumed in these interactions, opening up a possibility where a different orientation to patients experiencing “jail mentality” may become possible. Here, clinicians likewise come to embody a kind of “jail mentality”—seeing the hospital like a jail—for which they are also responsible. Finally, as a family member of people who have experienced both incarceration and involuntary care, I hope to draw critical connections between practices in both jail and clinical spaces that cannot be overlooked if psychiatrists and mental healthcare professionals truly wish to position themselves as an alternative to incarceration (see: Chapter One).

With these limitations, risks, and goals in mind, I explore how narratives about a patient may emerge, diverge and connect in critical ways to frame both the patient and medical responses to the patient. Here, perhaps, John’s silence becomes critical. The lack of John’s account of events exemplifies the ways in which patients subject to involuntary commitment temporarily lose not only their explicit rights to freedom but also control of the narratives told about them, their medical and psychiatric history and their relation to mental health care or, as Neely Myers discusses it in her work on recovery, their “moral agency” (Myers 2016, 2017; Hansen 2019).

The dialogically-born narratives as they develop among hospital staff over the course of the day are critical for understanding how the possibilities of their recognizing and interpreting another’s behavior may be institutionally foreclosed and how things could have transpired otherwise (cf. Ochs and Capps 2001). Chimamanda Ngozi Adichie closes her talk, “The Danger of a Single Story,” with this observation: “when we reject the single story, when we realize that there is never a single story about any place, we regain a kind of paradise” (2005). Such a paradise exists in the ways that we leave space for other narrators and other protagonists to exceed the categories or particular moments in which we encounter them. While the context in which I write feels far from paradise, perhaps something like a transformative ethnographic perspective[42] becomes possible in the ways that we might hold open our categorical ways of relating to each other for questioning (cf. Zigon 2018) and looking critically at the way such categories emerge.

Taking the narratives told about John not as final but as necessarily constrained and incomplete means leaving things like "jail mentality" open for critical engagement; unfreezing the taken for granted notions of "safety" and "care" through which such a mentality becomes visible (Mattingly 2019). Through such engagement, we may recognize broader institutional, cultural and political histories at play. In this way, "jail mentality" might come to represent not just the potential for threat as it emerges here, but also the consequences of a system which puts people of color, especially Black people, with mental health disorders at exponential risk for police violence and incarceration where trauma is reproduced and exacerbated (Cf. Grekin et al 1994; Appel et al 2020). Diving into the roots of violence and harm, we may see that individuals who cause harm are often also subject to harm—precipitated by others and the state, as it seeks justice, or even as it seeks to offer care. This condition does not justify violence but, rather, contextualizes it and perhaps brings us to a place of deeper understanding and accountability. Opening narratives in this way also means opening the narrative I recount for critique and conversation, as necessarily unfinished. Moving forward, I invite readers to consider the ways in which categories and conclusions about emergent behavior in these narratives are lodged within

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[42] Here, I am drawing explicitly from literatures on transformative justice (See for instance: Richie 2012; Kaba 2021).

hybridized institutional practices and broader social and cultural experiences of all involved, including me.

"Straight-up Street Stuff," "Straight-Up Jail House Behavior"

As they waited for nursing staff to prepare the leather straps and medication required for restraint, sheriff's deputies of the hospital patrol unit and nurses from the Psych ER, who had arrived as back-up when the "Code Gold" was called, gathered outside the closed door of John's patient room. Peering through the window in the closed door, a young deputy, pointed to the way that John used a pillowcase filled with his belongings as an exercise weight. That was "straight-up jailhouse behavior," she explained, indexing both her expertise and intimacy with those she had policed. All LA sheriff's deputies are required to first serve as guards in local jails or courthouses (which include managing courthouse "lock-ups" where people are detained while awaiting trial) before they are given other assignments (see for instance: Poole and Pogrebin 1988).

As time wore on and deputies grew impatient—the nurses preparing for restraints seemed to be taking some time—Officer Richards, a middle-aged phenotypically white man, explained what he understood was occurring on the unit that day as "inmate" and "gang behavior"[43] to me and the nursing students who were observing. It was a "Black and Brown

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[43] The focus on John and the other patients as involved in a gang rivalry reflects a local history of gang violence and gang policing in Los Angeles and in California prisons that is, unfortunately, beyond the scope of this dissertation. In the late 2000s, media outlets and research centers like National Public Radio and the Southern Poverty Law Center (2007) reported stories of growing gang membership and anti-black violence perpetrated by Latino gangs. NPR (2007) reported rates of gang membership of more than 40,000. Meanwhile, the aggressive, militaristic style that characterized LAPD gang policing in the 1990s (Davis 2006) was coupled with data surveillance techniques that depended on individual police discretion to determine who was a gang member or not. In 2016, this database was determined to be "plagued by errors" (Winton, 2016). In the years since evidence has surfaced suggesting not only that prison and jail guards may encourage gang violence, but are part of gangs themselves (See for instance: Dorotik 2011, Kennedy 2021). While it is possible that one or all the patients involved in this incident were or were once affiliated with a gang, no direct evidence was given. Instead, nursing staff pointed to graffiti, linguistic

thing," he claimed. "Straight-up street stuff." At the time, I was unware, though I suspected the deputies had been informed of the goings-on from the night before—the sharpened toothbrushes, the bent paperclip. Yet, it was unclear what at the moment was driving Officer Richards broad statements about gang rivalry.

John opened his door and stood in the doorway. The deputies and back-up nursing staff closed the circle tighter around him and the entrance to his room. It was hard to see and hear exactly what was going on from where I stood in the hallway. "Do you wanna get tied up?," I heard a person in the crowd ask. I moved to the other side of the hallway to view the circle as best I could at a distance from where John stood. Then, Deputy Richards pointed his Taser at John's chest. The laser beam moved across John's sternum and hovered around his heart, a possibly lethal threat. John stood with his arms down, open, apparently, remarkably calm.

Esther, who had been a physician in West Africa with training in psychiatry and had previously worked to train others in safe modes of crisis intervention and de-escalation, approached and convinced John to enter his room. She tried to coax him to sit down on his bed. I could not see, but I could hear vaguely as the tone in her voice changed from gentle coaxing to disappointment as he refused. Soon the rest of the nursing staff and the deputies entered the room. John cursed as the nursing staff held him face down on[44] his bed to administer an intramuscular injection—5mg Haldol, 2 Lorazepam, 50 Benadryl—a "cocktail"[45] of anti-psychotic, anti-anxiety, and anti-histamine generally strong enough to sedate even the most

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practices, and their own medical training and career histories working in carceral facilities with men who were or were assumed to be in gangs. The graffiti that John and the other patients involved had written in the hospital, I was told though never in detail despite probing, had marked the hospital unit into gang territories. The mobilization of assessments of gang-affiliation in this moment, regardless of their accuracy, serves to further bolster claims to John's "jail mentality" and former incarceration.

[44] This is a safety precaution used during restraint and involuntary medication to keep patients from kicking clinical staff.

[45] As many of the nurses on the unit referred to the shot.

agitated patients. John offered to turn himself over for the next part of the restraint process, but the nurses insisted on doing this themselves. “Just relax,” one of the onlooking deputies said. “Just relax” others repeated.

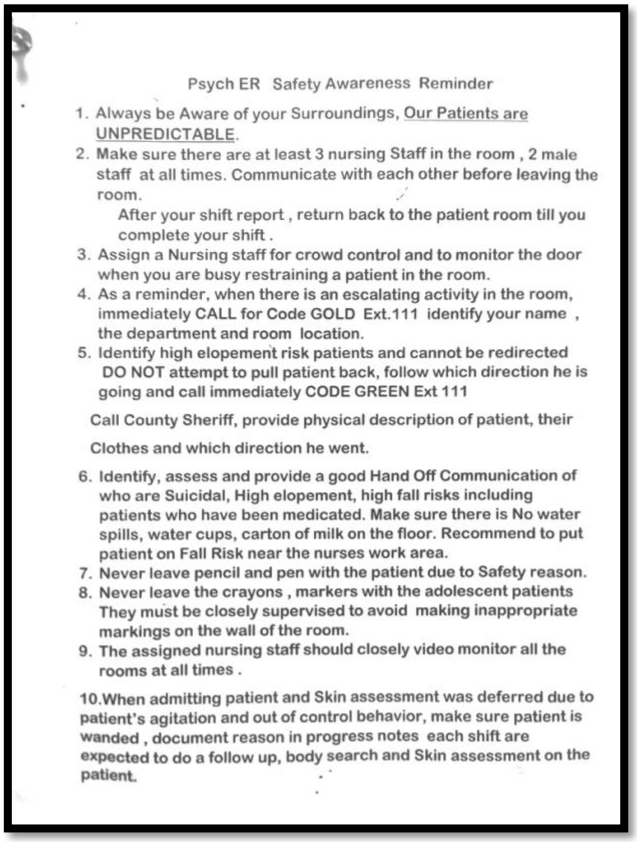
The nurses rolled John onto his back and tied down his restraints, one belt for each of his limbs and a strap across the waist to keep him confined in bed. While I was witnessing this moment, I was surprised by a deputy standing next to me, the same woman who had told me earlier about the weight bag. I had not noticed her leave the room. She leaned against the wall and told me that John was a former “inmate.” I asked her how she knew and she said the patient had said as much, but also she could tell by his demeanor, she explained. The way he carried himself. The way he made that workout bag with his pillowcase. That was something they did in prison.

Once John was restrained, Officer Richards re-entered the patient room. He tapped the side of the sink and the paper towel dispenser. He shook the bed. Then, he showed Esther the room, checking over the bed again. The two agreed that the patient should be moved to somewhere he could not hide as many things. The paper towel dispenser could easily be made into a weapon, the officer explained, they saw those kind of things happen in jail. John, meanwhile, grew angry, and he began to yell, launching insults. A nursing student who was observing in the hall remarked with surprise that he was still so agitated after the dose of sedative medication. Eventually, John calmed down. The deputies departed. According to notation documenting the restraint, all had gone according to procedure. No one was injured. Safety on the unit had been maintained.

Safety Logics and Vigilance at Los Angeles Public Hospital

Safety and its maintenance were topics of frequent conversation in LAPH. “Safety is the first priority,” I was told repeatedly. As both an imperative for those working at LAPH and the justification for various decisions, however, safety itself was rarely defined. Instead, safety operated as “not danger,” while danger presented itself in past, present and anticipatory ways. As the unmarked companion to danger, I learned to understand safety as palpable absence that must be actively constituted and then protected from ever-possible threat. What emerged through an ethnographic analysis of safety, was the fact that medical professionals worked to both constitute and maintain safety through institutional ethics and interactional practices that grounded in practices of vigilance.

In formal and informal comments during orientation training, patient intake, doctors’ rounds and nurse reports, medical staff encouraged each other to stay alert at all times, to stay safe. Suggestions for safety maintenance included instructions to keep backs to the wall while moving through the unit, to keep stock of where each person was in the unit, and to remain attentive to the environment even while focusing on individual patients themselves. In training for new medical interns—though attending psychiatrists were careful to note the over-emphasis in popular media on associations between mental disorders and violence—they nevertheless taught the new doctors the value of knowing where the exits were, planning escape routes before entering a room with a patient, and avoiding long ponytails, scarves or ties, lest patients pull them.



Psych ER Safety Awareness Reminder

1. Always be Aware of your Surroundings, Our Patients are UNPREDICTABLE.
2. Make sure there are at least 3 nursing Staff in the room , 2 male staff at all times. Communicate with each other before leaving the room.

   After your shift report , return back to the patient room till you complete your shift .
3. Assign a Nursing staff for crowd control and to monitor the door when you are busy restraining a patient in the room.
4. As a reminder, when there is an escalating activity in the room, immediately CALL for Code GOLD Ext.111 identify your name , the department and room location.
5. Identify high elopement risk patients and cannot be redirected DO NOT attempt to pull patient back, follow which direction he is going and call immediately CODE GREEN Ext 111

   Call County Sheriff, provide physical description of patient, their

   Clothes and which direction he went.
6. Identify, assess and provide a good Hand Off Communication of who are Suicidal, High elopement, high fall risks including patients who have been medicated. Make sure there is No water spills, water cups, carton of milk on the floor. Recommend to put patient on Fall Risk near the nurses work area.
7. Never leave pencil and pen with the patient due to Safety reason.
8. Never leave the crayons , markers with the adolescent patients They must be closely supervised to avoid making inappropriate markings on the wall of the room.
9. The assigned nursing staff should closely video monitor all the rooms at all times .

10.When admitting patient and Skin assessment was deferred due to patient's agitation and out of control behavior, make sure patient is wanded , document reason in progress notes each shift are expected to do a follow up, body search and Skin assessment on the patient.

Figure 4: Safety Awareness Reminder with 10 warnings, the first of which reminds those in the Psych ER that "Our Patients are UNPREDICTABLE."

These instructions were reinforced in documents posted throughout the unit. In a "Safety Awareness Reminder" (above) posted in the breakroom in the Psych ER, for instance, managerial staff reminded nurses and doctors that patients are "UNPREDICTABLE." The uncertainty of patient behavior required constant awareness of surroundings and observation of all patients at all times, especially while restraining another. Due to "safety reason[s]," pens, pencils, crayons, and markers were never to be left alone on the unit. Safety is defined, again, in relation to what it is not (e.g. it is not the patient, pen or pencil left unattended) and maintained in vigilant awareness, observation, and monitoring. So it is that in orientation training and in everyday practice, through formal warnings and reminders, vigilance is institutionally and socially constructed on the unit. Intercorporeally mediated and intersubjectively constituted fields of vigilance can thus be understood as the ground upon which safety, as a form of absent presence, was maintained.

Theorizing vigilance, Henrik Vigh (2011) makes a number of critical observations. First, in the post-war contexts of Belfast and Guinea Bissau where Vigh conducted his work, he notes how vigilance emerges in contexts of uncertainty informed by histories of trauma, violence and danger. Threat, in particular drives vigilant behavior. In the hospital space, such histories of trauma, violence and danger emerge in particular interactions but also become a matter of course in so far as the expectation for unpredictable patients in crisis informs the institutionalization of vigilant practices. Vigh argues that uncertainty informed by past trauma or experiences of danger drives an anticipatory or “pre-emptive” orientation toward the future as “negative potentiality.” This leads, Vigh argues, to a kind of “iconic” objectification of others. Phrased a little differently: within a vigilant moment, people may come to categorize others as objects for the vigilant gaze. Their behavior, their subject positions, their language—all of this is and more—is hyper-signified and may come to index danger or threat to vigilant observers (cf. Fanon 1967; Sartre (1984; 1943)).

Critically, the ways that anything may become subject to the vigilant gaze is through the careful non-observation of other kinds of information or distractions. In the hospital, staff must learn not only what to look out for, but also what may be safely ignored. In the midst of an often-crowded psychiatric unit with many patients in various states of crisis, discerning the dangerous from the merely distracting is easier said than done. Short-hands and habits develop. In the negotiation of the many sensory experiences that may pull at one’s attention (Throop and Duranti 2015), hospital staff and patrol units may call upon what Charles Goodwin (1994) has termed “professional vision,” an institutionally socialized form of interpretation to categorize and delineate behaviors in order to distinguish, in this case, threat. This professional vision is mobilized as a professional, vigilant stance, when for instance part of John's behavior and physical embodiment—his race as it relates to other patients on the unit and his behavior—index a "jail mentality" and thus a threat to others on the unit (cf. Fanon, 1967). Here, people working in the hospital call upon institutional and bureaucratic ideologies of both the criminal justice and public psychiatric systems in Los Angeles, deploying a variously hybridized "professional vision." While the paperclip as a banned object may represent a threat generally and, once found, would be removed from the patient environment in the same way an unattended pen or pencil might, other institutional practices that occur in LA county jails, including the segregation of incarcerated people by race to prevent potential violence as a result of "gang rivalry," inform how professionals respond to and otherwise understand their observations in this particular case as appropriate for vigilant attention. Indeed, "jail mentality" itself is a kind of hybrid phrase in so far as it pathologizes carceral experience, bringing it out of the realm of generalized knowledge and into a psychological shorthand.

Yet, there is more than mere professional vision at work here. From another perspective, the ways in which threat emerge in a particular situation—the ways in which threat presents itself as "jail mentality" in *this* particular situation—may be understood via Ludwig Wittgenstein's "aspect seeing," half visual experience, half thought—a context driven mode of perception (1958). To see something *as* something—a duck as a duck, a rabbit as a rabbit, a duck-rabbit as a duck-rabbit—is to see it from an embodied position within a social and historical context. Duranti (2015) relates aspect seeing to Husserl's notion of intentional modification to articulate how particular aspects of a phenomenon become distinguished from others which may sink into the background and expands aspect seeing to include hearing and talking. In the hospital, aspects of threat presented in states of individual and collective vigilance, particularly those heightened and more-mooded states of vigilance like the moments before, during, and after John's restraint, are experienced synesthetically amidst a confusion of physical sensations—sight-touch-sound—and affective responses through which personal and political histories of mental healthcare and incarceration are brought to bear in the felt experience of staff and on the bodies of their patients. Aspects of threat (in this case as jail mentality) as they present themselves on or between bodies brings typified knowledge of criminal or mentally disordered behavior out of the realm of abstraction. These knowledges are felt intimately, deeply, and mobilized not only to make decisions in the hospital but also to justify those decisions in a broader social and historical context.

"This is What We Are Going to Get"

Watching her colleagues restrain John from her position in another patient's room, Isabelle called me over. She had never been much interested in sharing her opinion with me as a psychiatric nurse attendant. Now, she made sure I was writing everything down. She had been telling her supervisor about John for two days. She whispered "supervisor." John needed more monitoring and intramuscular injections, but Esther attempted to de-escalate the situation instead. John probably needed to go to jail, Isabelle concluded. She'd seen this kind of behavior when she worked in prison. Only, in prison they didn't have to do the hands-on dangerous work they had to do in the hospital. In prison, the guards handled it, and they had protective gear. We just have scrubs she said, touching her top and then her pants. It wasn't enough, she indicated. They weren't paid enough, either, to endure the possible injuries from patients. With recent changes and the state releasing more inmates from prison, "this is what we are going to get:"

parolees on the unit who “don’t care,” she explained. It would be dangerous, if it wasn’t handled correctly. Not everything can or should be put through the paces of de-escalation techniques. Sometimes a patient “just needs a shot.”

As she gestured to her scrubs, placing her hands on her chest and then her legs, Isabelle located threat intimately. It was her body and the bodies of her fellow nurses at risk. Indeed, nursing staff had suffered broken bones and life-threatening injuries in interactions with patients. This bodily, felt experience—the vulnerability of her chest, her legs, her self—is coupled with another threat for Isabelle, a perceived wave of dangerous patients on the horizon (the result of the California Prison Realignment). These anticipatory and intimate experiences of threat affirm what Isabelle described as an instinctual knowing about John over the course of days, drawn from her work in prison. Here, without naming it, Isabelle foregrounds John’s criminal subjectivity while backgrounding his role as patient, demonstrating a practical logic—“he should probably go to jail”—which would foreclose the possibility of continued hospital care and its possible links to consistent community mental health care.

For other nursing staff with experience working in jail and prison, the decision about the course of John’s care was less decided, though other markers of his “jail mentality” and criminal subjectivity were identified in the form of his talk and the way he covered the walls of his room in blue (a “Crip” color) crayon. Alongside these discussions, and discussions of other patients involved were references to the sense of vulnerability that Isabelle conveyed through references to vigilant bodily comportment. It was important to carry yourself in a particular way, one member of the nursing staff told me. You learn how to present yourself for the patients, so that they don’t take advantage of you, another—without jail work experience—explained. Here, vigilance becomes performative, equally about the looking as the being looked at (cf. Desjarlais and Habrih, Forthcoming).

“If it Looks Like a Duck and Quacks Like a Duck”

Later in the afternoon, I found a break to visit the building that temporarily housed the LA Sheriff Department’s hospital patrol unit. Officer Richards had just arrived back from patrol and agreed to talk with me about the events on the psychiatric inpatient unit that morning. I told him that this was the first I had ever seen gangs or a gang rivalry discussed on the unit. Richards nodded, he saw it all the time when he worked on the jail, he explained. This was how gangs emerged in a jail environment, he continued, it was often a “Black and Brown thing.” He spoke with authority, explaining that there was a lot of mistrust between the races. He reminded me of the “gang writing” all over the patient’s room. To me, the writing was not indistinguishable from the hypergraphia I had seen on the unit before. I asked if he knew what it said. Richards replied that he didn’t but could recognize it was gang affiliated.

Richards continued, telling me that the patient himself said he had been incarcerated in a particularly notorious prison upstate. Richards told me to take this with a “grain of salt” but asked me to assume with him that the patient had been in prison. This patient, Richards continued, in addition to whatever he carried with him from jail, also had a mental disorder. All of these factors signaled danger. The day before, Richards continued, the patient had a run-in with Hispanic patients, three of them. They got into a fight. A nurse stomped them, and John stomped on the nurse’s foot. “Well,” Richards told me that he liked to joke: “If it looks like a duck, quacks like a duck . . .” This patient had a “jail mindset” plus a mental imbalance. He was likely to hurt someone. The hospital staff see hundreds of “inmates”—he corrected himself—

“patients” and only once in a while do things get violent. “You have to think and plan for the violent one, if that comes up,” he explained.

Officer Richards continued to list the factors of risk in this particular situation, repeating himself as he went: that patient, his size, his time in jail, his mental imbalance. He could hurt one of the staff very easily, he continued. There are so many pieces on the medical bed in his room, for instance, Richard continued. “I could have broken off” so many pieces. It would be like “going to the cutlery section at Wal-Mart.” All of this spoke to the ways staff were “ill-prepared for this particular threat: their equipment, the mindset of the unit. They have open doors on all the patient rooms, for instance, he explained. In the process, Richards outlined a different professional vision, one which cast the medical staff’s own vision of safety, danger and threat as lacking or otherwise naïve. A clash emerges in how the hospital as institutional world appears for law enforcement as opposed to medical professionals. Different possibilities of being and meaning (i.e. what is dangerous, what is safe) emerge even while they remain similarly embodied.

Richards continued, explaining how he aimed the Taser at John’s chest because he [John] may “go off and I’m not going to play games.” Richards needed to let John know that. Most of the time, Richards explained, the patients turn around and leave without having to be told. That brought him to another thought about the way they handled thing in the inpatient unit: “the speed at which you react makes a huge difference in how things proceed. They waited a very long time, just gathering around the door like that. If there’s the slightest bit of hesitancy, predators like him key into that.” The trick, Richards explained, was not to appear unsure or week. “He senses that.” Using animalistic metaphors that are deeply raced while framing this as a matter of life and death—as opposed to power—one that has no room for any ethics of hesitancy (Al-Saji 2014).

John was trying to intimidate, Richards continued before I could ask another question. The officer pulled his shoulders back and puffed up his chest, moving very close to me, only the length of my notebook between us. It was all about the body language, he explained. Perhaps sensing that I was intimidated (and I was), Richards continued: “You know I’m not going to hurt you,” but we don’t know that about patients like John. “That guy is really capable of putting the hurt on.” Stepping back, I asked him again about the way he understood the conflict developing between patients, why they focused on John and not the other patients and whether he thought the Prison Realignment had changed the patient population.

After addressing the practicalities of moving and restraining one patient rather than three, Richards turned his focus to the incidents of patient violence that he knew had occurred at LAPH. A patient had punched a staff member eight months ago. A patient had punched another nurse in the face, breaking the orbital bone. Richards acknowledged that the impact of realignment would be hard to predict, but that it would make sense for there to be some effect on the hospital, given the number of “mental problems” in state prisons and prison inmates’ propensity for violence. He had heard about stuff in the state prisons that would literally curl my hair, he told me.

I asked Richards about the restraint. Was it standard procedure? It did not seem very remarkable to him, and again he re-directed the conversation. There are hundreds and hundreds of patients who come through the unit, which is sad, he reflected. There are patients who are “frequent flyers.” They cooperate. They just need help. But, then, there are patients like John in the world who are mentally ill and maybe not willing to get help. Maybe driven by other motivations, gangs, hatred—there are some who live, breath, and are willing to die for a culture—the gangs, he explained. “It’s literally like their own country.” They have their own language, values, hierarchy. It is their own world. That would never happen to someone like you and I, he said, but to them, its normal.

I reflected back on the moments leading before the restraint and told Richards that I had not seen much of a reaction from the patient when Richards aimed the taser at his chest. I asked Richards what he saw. “They learn not to react outwardly,” he told me. But the patient did seem to comply, I said. He was testing Richards, he explained and Richards let him know he was not afraid to pull the trigger. The patient could have kept coming, but he didn’t “this time.” They were lucky, this time. “I hope I’m wrong” about the patient, Richards continued, but it was a risky bet to make. A person like that, with an organic psychotic issue, not caring about life, plus mental illness, plus his size was a “dangerous, dangerous combination.” Richards sighed. He thought it would take a 9-11 type event before there were any major changes on the unit. The hospital took some precautions for patient recovery (like keeping the unit relatively open and using bed frames with multiple parts) but in doing so made themselves vulnerable to other problems. “Safety is a two-edged sword,” he reflected.

A hospital context might have brought to the fore John’s position as “patient.” Yet, prior to lifting his taser, Deputy Richards had seen in John aspects of a criminal. “If it looked like a duck and quacked like a duck.” John appeared as a figure who had carried incarceration so deeply within him that he now had a “jail mindset.” Richards’ account of the event suggests that he felt an unspoken understanding of and with the patient, an assurance, a knowing. When the patient stood still, he affirmed a “jail mindset,” having learned not to react outwardly. In the test drawn by the Taser’s beam between patient and deputy, the patient’s positionality as “predator,” threat and dangerous other is affirmed, deeply. And, here, I take seriously the kind of animal, subhuman, othering kinds of metaphor used in Richard's speech to materialize this "jail mentality." Richards was not only seeing-as a deputy on the hospital patrol unit, but speaking as such a deputy and—in doing so—he mobilized his personal experience embedded in a history of national and local mass incarceration to position John as an object of carceral and not medical attention. Attended to via the vigilant gaze, John is moved beyond the realm of therapeutic care, but—further—beyond the realm of basic social recognition. Richards chose to aim the Taser at a patient whose medical history he did not know. He aimed the Taser at John's chest, turning the device effectively into a defibrillator. Not afraid to pull the trigger, Deputy Richards held the position of what could have been a deadly shot (Zipes 2012).

There was another potential in this moment between John and Richards and at a more distant level between Isabelle and John; one where John's vulnerability and role as patient was foregrounded. Why was this not the case? The heightened sense of threat may certainly explain a quick jump to recognize and categorize a person as dangerous or criminal. Perhaps more can be understood by slowing the jump, to engage the vigilant gaze and its return more critically. Here, I am drawn to reconsider the performative aspects of vigilance. As Isabelle places her hands on her scrubs to demonstrate her exposure and the risk she faces, as Richards puffs out his chest to demonstrate an intimidating posture or reflects on the John's response to his raised Taser, the nurse and the officer demonstrate double-edged and dangerous aspects of vigilance itself (cf. Desjarlais and Habrih, Forthcoming). In these moments, the vulnerability and danger of being vigilant can be distilled in what Sartre called "being-seen-by-the-other," the irreducible moment wherein the gaze is reversed and it becomes apparent that the Other who might otherwise be mere object to the viewer has the potential to return the objectifying gaze. This "being-seen" is captured in some ways by the attribution of “jail mentality,” where John’s potentially objectifying gaze is recognized and worked over so that he may be dehumanized. Here, we may see the active work required to refuse or otherwise unsee the “who” of John, that is his existence as a person in the world—even in the throes of mental illness--for whom there are multiple stakes including the control of how his narrative is negotiated and developed. This becomes apparent in the way both Isabelle and Richards conclude that John “doesn’t care”—about the social world, about the vulnerability of others, the object of care is unclear. Instead, following Taylor (2008), perhaps caring and the capacity to care respond generally to one’s capacity to be in the social world with others, recognizing them, in turn being recognized. To have a “jail mentality” to not “care,” is, then, to embody a kind of social death, and be unworthy of care.

Jail and Jailer Mentality: Care, Safety and Freedom at LAPH

“The prison mentality is simply a microcosm of the United States, albeit an exaggerated and very brutal microcosm” – Jane Dorotik

In the context of a health care department that prioritizes safety first, how is care practiced? With my eyes closed, I can point to a moment in my fieldnotes where clinician performs an act of care—delivering medication for someone in need, supporting recovery by finding an appropriate site for follow-up care, listening to a patient or their family members in distress. These moments of care are only possible in so far as everyone on the unit is safe. There are moments however—particularly when vigilance is heightened beyond its everyday maintenance on the unit—when safety becomes conflated with care and care becomes, broadly, a matter of protection for self and others. Indeed, in many of my interviews doctors and nurses talked about safety measures, including physical restraint, as "therapeutic." In line with their work as a care unit, then, such safety and its maintenance are not only a value but a virtue.

Along these lines, it is helpful to closely consider the OED's definition of safety as "freedom from danger" (OED, 1a). Attending to the ways in which safety operates as a kind of minimal freedom, provides a context in which to interrogate the political and institutional ideologies about obligations to others become apparent in practice. As "freedom from," safety signals a negative liberty where danger is seen as a constraint to the operation of this freedom (Berlin 1969, 122-23; Mahmood 2012 [2005]; Zigon 2019, 105). Indeed, safety underlies many articulations of freedom generally, where an individual's freedom may be prioritized until they encroach on or endanger the life and freedom of others. To be "safe" here could be seen as a foundational freedom that provides the space for the individual to do and be other things as well. While sovereign freedom of the individual operates in this form of safety, it also speaks to a larger institutional ideology of discipline, mastery, and control of which clinicians themselves are not only practitioners but to which they are also subject in the form of legal and bureaucratic liability.

While many working in the unit understood and described physical restraint as "therapeutic," recent research and countless patient testimonies suggest otherwise (See for instance: Shomo 2013). In a survey of patients recently restrained Wong *et al.* 2020 found not only that the experience itself was deeply traumatizing and influenced how patients related to mental health care long after the fact, leading many not to seek care in times of need. Such articulations of restraint demand deeper scrutiny regarding the broad acceptance of restraint as a safety measure and also the limits to safety on the hospital unit. The question then becomes not how is safety a priority but whose safety is a priority. To understand this, it is helpful to consider the era in which involuntary commitment laws were written: the late 1960s at the tail end of social welfare economics and during the emergence of neoliberal politics that delimited state responsibility for care. In this liminal space "public safety" emerged as a chief concern for legislators, even while "dangerousness" and preventative jailing was critiqued by those guiding the passage of new involuntary commitment laws (Bardach 1972).

This was also the period immediately following the passage of the Civil Rights Act and the decades long fight against Jim Crow Laws and the segregation and discrimination that they protected. During this period paranoid schizophrenia was developed as a diagnostic response and dismissal of anger and fear in the Black male population (Metzl 2009; Hansen 2019). It also served to position Black men, yet again, as particularly dangerous and irrationally so, cementing a link between race and insanity that has existed for centuries in America (Metzl 2009). It is difficult not to see race and the shifting social landscape of the time in the emphasis on dangerousness in California Involuntary Commitment Laws and the rapid rate at which "danger to self and others" became the standard for commitment across the country (Anfang and Applebaum 2006). In this light and in the context of a county that incarcerates the most people in the country and a country that incarcerates more people than anywhere in the world and uses this practice disproportionately against Black people and people of color, there seems little question about whom safety under the law protects, even while some white people may be subject to the same treatment at lesser rates. "Jail mentality," then, becomes yet another diagnosis in a long history of efforts to pathologize the reasonable response of many Black people to unjust and traumatizing captivity.[46]

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[46] Here, I am thinking of drapetomania, or dyaesthesia aethiopis, which were diagnoses given to slaves who attempted to run away from their white masters (cf. Metzl 2009)

In the hospital, “jail mentality” represents a hybridized professional vision that speaks to the slippage between the hospital and jail systems in Los Angeles in practice (and under the law) and the circulation of patients and professionals through these systems. The potential for “jail mentality” to emerge was a conscious concern not only for some medical staff in the patient population but also for some attending psychiatrists as they considered their co-workers and the design of the locked unit. While one psychiatrist discussed former nurses who acted with a “police type mentality,” another evoked the Stanford-Prison-Experiment to describe the potential for such a mentality to emerge in anyone working on the unit: “it’s easy to take on the role of being the jailer and the patients are the prisoners and be very controlling and tell them if you don’t do X, Y, and Z, I’m going to give you a shot of Haldol and take on that sort of punitive attitude and it’s really important not to fall into that mentality.” Both spoke of the dangers of such mentalities and the ways they prevented care workers from recognizing their patients as sick and in need of care. The uneven and emergent aspects of “jailer mentality” on the unit, speak to it as a particular type of potentiality in the hospital, one that can swiftly emerge given the right conditions of possibility, but also one that does not encompass or define the institution without remainder. We may see this in the tensions between Esther’s attempts to deescalate the situation and Isabelle and Richard’s claims that there is no time for such de-escalation, for instance.

Beyond the hospital walls “jail mentality” is used regularly in prison and jail contexts to describe individuals who are unable to give up adaptive practices of hyper-vigilance, reactive anger, and defensiveness developed while incarcerated. It speaks to the high rates of PTSD experienced by both people who are incarcerated and prison guards (See for instance: Goff et al 2007) and the generally traumatizing effects of policing and prison culture as it informs how we relate to and understand crime, danger, and achieving safety and justice. Writing from prison before the California Realignment, Jane Dorotik describes an all-encompassing and devastating "prison mentality:"

> There exists a prison mentality, a way of thinking, that is hard to understand or even describe unless you have experienced it firsthand. Unfortunately, I have experienced it firsthand—and continue to experience it—and I believe the prison mentality is *the* most devastating aspect of being incarcerated, worse than restricted freedom, worse than being separated from family and friends, worse than being prevented from leading a normal and healthy life.
>
> There is an attitude, a mindset, a culture of dominance that is so pervasive and so totally devastating that it is truly astonishing to observe. This culture of domination is all encompassing, not just specific to the guards or the managerial staff; it seems to infect and become a way of being and thinking for all prisoners, all who come in contact with it (109-110)

The "prison mentality" is a microcosm of the US, Dorotik writes, pointing to the ways that dominance and control and the "hierarchies of importance" that shape this dominance frame the ways that the US government operates internationally and in its own territory. This culture of dominance, which positions some people as unworthy or unredeemable has escalated, such that prisons have proliferated across the country and especially in California to very profitable ends (Wilson Gilmore 2007). It serves, Dorotik writes, to justify violence, where guards encourage those incarcerated to beat each other up and the gang violence so sensationalized in popular media is protected and even encouraged (Dorotik, 112). This mentality affects not only those directly-impacted by the prison system, but also the broader system of justice. America's "prison nation" includes victims of harm, especially Black women, who are more often criminalized and subject to further violence when seeking help from the police (Richie 2012). A "prison nation," Beth Richie, a professor of Criminology Law and Justice, writes, "refers to those dimensions of civil society that use the power of law, public policy, and institutional practices in strategic ways to advance hegemonic values and to overpower efforts by individuals and groups that challenge the status quo" (3). Such a nation mobilizes punishment and regulation to manage the behavior of poor or disadvantaged communities and "depends on the ability of leaders to create fear. . . ; to identify scapegoats...; and to reclassify people as enemies of a stable society" (ibid). Such articulations of the broader culture of punishment and dominance in the US speak not only to the ways that justice is broadly conceived (ways which rarely offer real accountability, reform or a sense of safety for those who are victims to harm) but also to the ways in which emotions and attention are socialized within such a culture. Under such dominance imagining and enacting alternative responses to potential threats becomes near impossible, as fear is shaped at its core by threats identified by those in power.[47] Steps to insure safety, inevitably, become shaped by these fears and the ways in which they were cultivated.

As it stands, LAPH psychiatric care requires active vigilance, and alert care workers will likely always be necessary for responding to someone experiencing psychosis or other forms of extreme distress. Yet, such vigilance may look very differently in a culture that prioritizes early and easily accessible mental health care, where involuntary commitment laws are not based in conceptions of dangerousness so deeply rooted in the country's history of racialized policing. Considering a single moment of heightened vigilant response discloses not only the detailed mechanisms of vigilant response but also the ways vigilance responds to and reproduces the culture, histories, and the structures from which they emerge.

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[47] This may be one way to understand why many advocates for people with mental disorders, like those at the Treatment Advocacy Center, promote increased involuntary commitment procedures and increased training for law enforcement often over and above their work for broader, more accessible mental health care at preventative stages.

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> “Thus, action and reaction among men never move in a closed circle and can never be reliably confined to two partners. This boundlessness is characteristic not of political action alone in the narrower sense of the world, as though the boundlessness of human interrelatedness were only the result of the boundless multitude of people involved, which could be escaped by resigning oneself to action within a limited, graspable framework of circumstances; the smallest act in the most limited circumstances bears the seed of the same boundlessness, because one deed, and sometimes one word, suffices to change every constellation.”
>
> –Hannah Arendt, *The Human Condition*

In her reflections on action, Hannah Arendt moves in one page from the boundlessness of the smallest act to the frailty of human institutions (1998 [1958[). The move is one which should remind readers that institutions are, after all, a congregation of human beings in action, human beings who move, and change and respond to one another. Human beings with the capacity, in one deed or one word, to “change every constellation.” There is a habit in much of the discourse on institutions to view them as totalities, as complete and unchanging structures—as perpetual motion machines whose revolutions have no origin and cannot be stopped. Yet, by attending to the way people see and move through an institutional world, by attending to the way people think, feel and act, we may see how they variously shape the conditions of possibility for an institution and the world it informs. Institutions are, indeed, frail and porous. They can be influenced. They can be changed and are changed in the everyday actions of those who work within and beyond them.

In this dissertation, I have tried to take seriously the ways in which we make our worlds through our interactions with others. I have deployed a critical phenomenological approach that takes language praxis and mood seriously as a means for understanding the conditions which make a given system possible. In attending to the way that people engage the world as it appears to be via expressive language and mood—for instance, referring to and visualizing a hospital as a "jail" or a "revolving door"—I have also sought to outline the ways in which the world can be otherwise—for instance, recognizing a patient is not a "dangerous kid" but a child in need of care, as Alice had done in her role as patient advocate. In the boundlessness of every action, is the seed of a potential otherwise. People can speak this otherwise into existence, even if only for a moment.

I have been deeply humbled by my work in Los Angeles Public Hospital. For a little over a year, I watched as clinicians stretched their resources—their time, their space, their bodies—to provide care for people in states of extreme crisis. As I write this brief coda to a relatively brief dissertation, I am reminded again of Alice's work as a patient advocate and her approach to caring for patients. Alice began every interaction with patients, she told me, from a place of love. Inspired, I end my dissertation from a place of love. Love is, after all, the meaning that makes the risk of loss—a risk that profoundly shaped how I have seen and read my ethnographic work in the years since my sisters passing—meaningful. The other side of grief, love is a space where even those we have lost continue on, a form of boundless being with others that—if we do it right—may leave us open to as yet unspoken possibilities for being. Love is the profoundly radical grounds upon which we may openly dwell with others. It is also the place, as Alice explained, where we can be productively "tough." Though I have been critical about aspects of care in LAPH and believe there are ways in which this care can be changed for the better, I write these critiques from a place of love; love for the people who stretch themselves thin every day to care for others, and love for the many people who need this care. I can never do justice to the important work that takes place at Los Angeles Public Hospital every day. I can only hope to show, with love, the many possibilities this work opens up for how people may be with and care for others experiencing crisis.

APPENDIX:

Transcription Conventions

My transcription conventions follow those used by Ochs and Capps (2001)

(( ))	Mark descriptions of behavior during the stretch of talk
< >	Indicate that the enclosed talk is notably slower
> <	Indicate that the enclosed talk is notably faster.
Word	Marks a stress or emphasis on the underlined part of speech
-	Indicates a self-interruption or cut off
.	Indicates a falling intonation, not always at the end of a sentence
?	Indicates rising intonation, not always a question
:::	Indicates a drawing out of the preceding sound, length of the sound is proportional to number of colons used.

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